NEBRASKA HEALTH & HUMAN SERVICES SYSTEM
Preventive Health and Health Services Block Grant

Application

Original Application for Fiscal Year 2006
Submitted by: Nebraska
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Contents

Executive Summary

The Nebraska Health and Human Services System (NHHSS) submits the following **Original APPLICATION for Preventive Health and Health Services Block Grant (PHHSBG) funds for federal fiscal year 2006 (October 1, 2005 to September 30, 2006).**

This Original Application is subject to revision due to changes in Nebraska's allocation and subsequent decisions about the use of these funds during FY2006. Any needed revisions of the Application will be handled in accordance with policies of the Nebraska Preventive Health Advisory Committee and the Nebraska Health and Human Services System, and in compliance with pertinent Public Health Services Act provisions.

Implementation of the activities described in this Application was made contingent upon receipt of sufficient federal funds.

The Nebraska Preventive Health Advisory Committee is scheduled to meet and hold a public hearing on December 05, 2005. Recommendations made by the Advisory Committee on use of funds will be forwarded to the Policy Cabinet of the Nebraska Health and Human Services System (NHHSS), which has final decision making authority.

As required, a list of meetings and hearings is included in the Statutory Information section of this Application. The Meeting Minutes for the September 29, 2005 meeting have been entered. The Public Hearing Notice and Minutes currently appearing in that section are those for the previous fiscal year. The documents for FY2006 will entered when the Application is revised and resubmitted.

The designated chairperson of Nebraska's Advisory Committee is Jacquelyn Miller, Deputy Director of Health Services, within the Regulation and Licensure agency of the NHHSS.

This Application addresses national-level Healthy People 2010 objectives, which were selected as priorities for Nebraska. The selection was based upon a variety of data (morbidity, mortality, years-of-productive-life, health status disparities among racial/ethnic minorities, and behavioral risk) and upon resource availability. To the extent possible, the State Health Objectives in this Application match those in "Nebraska 2010: Health Goals and Objectives", published in May 2002 by the NHHSS.

This Application is divided into seven programs:

- DIABETES PROGRAM,
- EMS PROGRAM,
- INJURY AND VIOLENCE PREVENTION PROGRAM,
- LABORATORY TESTING PROGRAM,
- PHYSICAL ACTIVITY AND NUTRITION PROGRAM,
- PUBLIC HEALTH INFRASTRUCTURE PROGRAM, and
- SPECIAL POPULATIONS PROGRAM.

Each program addresses one or more national Health Objective (HO). The programs incorporate the work plans and budgets of subgrants within the NHHSS and to local health departments.

Funds are administered through the Centers for Disease Control and Prevention (CDC) in accordance with the Public Health Service

Act, Titles I-V (Public Law 78-410); as added by the Omnibus Budget Reconciliation Act of 1981, Title XIX, Part A, Sections 1901-1907 (Public Law 97-35); amended by Preventive Health Amendments of 1984 (Public Law 98-555); Omnibus Programs Extension of 1988 (Public Law 100-607), and Preventive Health Amendments of 1992 (Public Law 102-531). [The Crime Bill of 1994, Violence Against Women Act, which added Section 1910A, Rape Prevention and Education, was repealed in 2000 by Public Law 106-386.]

Statutory Information

Dates:

Public Hearing Date(s):	Advisory Committee Date(s):
12/01/04	**12/01/04**
12/05/05	**09/29/05**
	12/05/05

Current Forms on File with CDC:

Certifications: Yes
Certifications and Assurances: Yes

Budget Information

NEBRASKA HEALTH & HUMAN SERVICES SYSTEM
Preventive Health and Health Services Block Grant

Original Application for Fiscal Year 2006

Budget Detail	
Total Award (1+6)	$1,995,155
A. Current Year Annual Basic	
1. Annual Basic Amount	$1,953,250
2. Annual Basic Admin Cost	($195,325)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$1,757,925
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$41,905
7. Sex Offense Admin Cost	($4,190)
(8.) Sub-Total Sex Offense Set Aside	$37,715
(9.) Total Current Year Available Amount (5+8)	$1,795,640
C. Prior Year Dollars	
10. Annual Basic	$46,174
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$46,174
13. Total Available for Allocation (5+8+12)	$1,841,814

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$1,757,925
Sex Offense Set Aside	$37,715
Available Current Year PHHSBG Dollars	$1,795,640
B. PHHSBG $'s Prior Year:	
Annual Basic	$46,174
Sex Offense Set Aside	$0
Available Prior Year Dollars	$46,174
C. Total Funds Available for Allocation	$1,841,814

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL PHHSBG $'s
DIABETES PROGRAM	5-5 Diabetes	$56,757	$0	$56,757
Sub-Total		**$56,757**	**$0**	**$56,757**
EMERGENCY MEDICAL SERVICES TRAINING PROGRAM	1-11 Emergency Medical Services	$314,385	$46,174	$360,559
	23-5 Data and Information systems	$50,706	$0	$50,706
Sub-Total		**$365,091**	**$46,174**	**$411,265**
INJURY AND VIOLENCE PREVENTION PROGRAM	15-6 Child fatality review	$10,000	$0	$10,000
	15-13 Unintentional injury deaths	$20,000	$0	$20,000
	15-20 Child restraints	$50,832	$0	$50,832
	15-27 Falls	$20,000	$0	$20,000
	15-35 Rape or attempted rape	$38,219	$0	$38,219
	26-1 Alcohol and drug-related motor vehicle crashes	$25,000	$0	$25,000
Sub-Total		**$164,051**	**$0**	**$164,051**
LABORATORY TESTING PROGRAM	13-1 HIV-AIDS	$53,894	$0	$53,894
	25-1 Chlamydia	$153,771	$0	$153,771
	25-2 Gonorrhea	$12,550	$0	$12,550
	25-3 Primary and Secondary Syphilis	$40,600	$0	$40,600
Sub-Total		**$260,815**	**$0**	**$260,815**
PHYSICAL ACTIVITY AND NUTRITION PROGRAM	19-2 Obesity in adults	$42,075	$0	$42,075
	19-3 Overweight or obesity in children	$67,075	$0	$67,075

	and adolescents			
	22-1 Physical Activity in Adults	$87,076	$0	$87,076
	22-6 Physical Activity in Children and Adolescents	$42,076	$0	$42,076
Sub-Total		**$238,302**	**$0**	**$238,302**
PUBLIC HEALTH INFRASTRUCTURE PROGRAM	23-2 Public health access to information and surveillance data	$25,000	$0	$25,000
	23-4 Data for all population groups	$47,243	$0	$47,243
	23-5 Data and Information systems	$28,971	$0	$28,971
	23-10 Continuing education and training	$48,145	$0	$48,145
	23-11 Performance standards	$65,000	$0	$65,000
	23-12 Health improvement plans	$75,000	$0	$75,000
	23-15 Model statutes related to essential public health services	$10,000	$0	$10,000
Sub-Total		**$299,359**	**$0**	**$299,359**
SPECIAL POPULATIONS PROGRAM	7-5 Worksite health promotion programs	$25,000	$0	$25,000
	7-10 Community health promotion programs	$238,260	$0	$238,260
	7-11 Culturally appropriate community health promotion programs	$115,639	$0	$115,639
	16-1 Fetal and Infant deaths	$20,000	$0	$20,000
	27-10 Exposure to environmental tobacco smoke	$12,366	$0	$12,366
Sub-Total		**$411,265**	**$0**	**$411,265**
GRAND TOTAL		**$1,795,640**	**$46,174**	**$1,841,814**

Programs, Health Objectives, and Essential Services

Service 1 - Monitor health status
Service 2 - Diagnose and investigate
Service 3 - Inform and educate
Service 4 - Mobilize partnerships
Service 5 - Develop policies and plans
Service 6 - Enforce laws and regulations
Service 7 - Link people to services
Service 8 - Assure competent workforce
Service 9 - Evaluate health programs
Service 10 – Research

NEBRASKA HEALTH & HUMAN SERVICES SYSTEM
Preventive Health and Health Services Block Grant

Original Application for Fiscal Year 2006

State Program Title: DIABETES PROGRAM

State Program Strategy:

👁 The Nebraska Health and Human Services System (NHHSS) has a comprehensive program to prevent *Diabetes Mellitus* and its complications. As outlined in the State Health Problem section of this Application, diabetes is an increasing problem in Nebraska, affecting the elderly and people of color at a disproportionate rate.

⏩ **Strategies selected for the PHHSBG-funded Diabetes Program include patient education, care standards and prevention education for high-risk children.**

The PHHS Block Grant-funded Diabetes Program expands the services provided by the NHHSS Nebraska Diabetes Prevention and Control Program. It allows NHHSS Diabetes Control Program to contract with providers of care for minority people with diabetes and contract with a school for a nutrition and physical activity program to help prevent diabetes in Native American children. The funding also supports a project operated by a district health department, aimed at the Hispanic population in two counties.

NHHSS Programs:

The Nebraska Diabetes Prevention and Control Program (NDPCP) has as its goal the reduction of diabetes-related disability and death in Nebraska, and the improvement of the quality of life and medical care for people residing in Nebraska who have diabetes. In recent years, the program has attempted to address these goals largely through public and professional education.

With the assistance of physicians and other health care providers, the program has also recently developed a set of guidelines for the clinical care of people with diabetes (known as the Nebraska Diabetes Consensus Guidelines). The program is now working to encourage medical care providers throughout the state to adopt the Guidelines for use in their own practices.

The Nebraska Diabetes Prevention and Control Program is funded by the Centers for Disease Control and Prevention, an agency within the U.S. Department of Health and Human Services System.

[Adapted from "The Burden of Diabetes", May 2003, NHHSS]

National Health Objective: HO 5-5 Diabetes

State Health Objective(s):

To reduce the diabetes death rate to no more than 25.0 per 100,000 population, by September 30, 2010.

[Baseline: 50 per 100,000 population, age 18 and over, 1994 to 1998]
[This is an ambitious target rate, particularly for Native Americans, African Americans, and Hispanic Americans where mortality rates are especially high. The Target rate was set using the "better than the best" method suggested in the Healthy People 2101 documents, with Asian Americans having the "best" rate in Nebraska of 27.2 deaths per 100,000 population.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

To increase the proportion of adults with diabetes who have a glycosylated hemoglobin (Hemoglobin A1c) test performed annually to at least 50%, by September 30, 2010.

[Baseline: 27%, BRFSS Survey, persons aged 18 and older reporting ever having been diagnosed with diabetes, and report that a doctor, nurse or other health professional has checked the respondent's glycosylated hemoglobin in or more times in the past year.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)
[Update: According to the 1999 BRFSS, less one third of Nebraska survey responders with diabetes recalled having glycosylated hemoglobin or hemoglobin A1c test done in the past year.]

State Health Problem:

Cause of Death:
Diabetes was the seventh leading cause of death in Nebraska in 2002 and 2003, causing 392 and 406 deaths respectively. During 2003, it was the fourth leading cause of death among 45-59 year old males, and the fifth leading cause of death among 45-59 year old females Nebraskans. The diabetes death rate for the 1999-2003 period was 20.0 per 100,000 population. *[Source: NHHSS 2002 and 2003 Vital Statistics Reports]*

Prevalence:
In Nebraska, data from the 2000 BRFSS estimate that the prevalence of diagnosed diabetes among adults was 5.4%. Excluding gestational diabetes, the rate was 4.9%. This figure translates into a statewide population of over 60,000 adults with diabetes. In addition, there were approximately 20,000 Nebraskans who had diabetes in 2000, but were not aware of it.

Nebraska BRFSS data for the past decade do not show a significant increase in the percentage of adults with diagnosed diabetes (in 1990, the figure stood at 4.6%), but evidence from other data (particularly the striking increase in the prevalence of obesity that occurred among Nebraska adults during the 1990s) suggests that the prevalence of diabetes has probably increased more than indicated by recent BRFSS findings.

Diabetes Facts:

• Diabetes disproportionately affects Nebraska's elderly. About one of every nine people 65 years of

age and older have been diagnosed with diabetes, and this age group now comprises over 40% of Nebraska's total population with diabetes. Since most of Nebraska's future population growth is expected to occur among our oldest citizens, the number of people with diabetes will grow substantially.

• Obesity is an important risk factor for diabetes, and more than one in five Nebraska adults is now obese. During the past decade, the percentage of Nebraska adults who are obese has almost doubled.

• Nebraska adults with diabetes are more than twice as likely to be obese and to have high cholesterol, and are more than three times more likely to have hypertension, than are Nebraska adults who do not have diabetes.

• Approximately one of every nine hospitalizations in Nebraska involves a person with diabetes. On average, a diabetes-related hospitalization costs nearly 40% more than a non-diabetes-related hospitalization.

• People with diabetes account for nearly two-thirds of all non-traumatic lower-extremity amputations performed at Nebraska hospitals.

• People with diabetes account for more than two of every five cases of end-stage renal disease diagnosed among Nebraska residents. During the past decade, the annual number of diabetes-related end-stage renal disease diagnoses in Nebraska increased by 164%.

• During the past decade, diabetes was the seventh leading cause of death among Nebraska residents. The state's annual diabetes mortality rate increased by nearly 50% during this period.

• African-Americans, Native Americans, and Hispanics who live in Nebraska are substantially more likely to die from diabetes than are whites.

[Source "The Burden of Diabetes", May 2003, NHHSS]

Target Population:

Nebraska defines the Target Population as all people with diabetes in Nebraska.

The number of people with diagnosed diabetes was estimated at 67,000 in 2003, with an additional 20,000 undiagnosed .

[Source: "The Burden of Diabetes in Nebraska", published May 2003].

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as people with diabetes who are also members of a racial or ethnic minority group, and/or do not have a Hemoglobin A1c test performed annually, so their level of control is not well defined.

African Americans, Native Americans, and Hispanics who live in Nebraska are substantially more likely to die from diabetes than are whites.

Only about one-fourth (28.3%) of Nebraska adults with diabetes have had a glycosylated hemoglobin test (also called the hemoglobin A1c test) within the past year, according to the BRFSS.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To improve patient education to adults with diabetes, by September 30, 2009.

Annual Activity Objective: Subawardee will contract for patient education services, by September 30, 2006:

- Panhandle Community Services (PCS), which serves Native Americans and Hispanics in Scotts Bluff County;
- Nebraska Medical Center Diabetes Program, One World Community Health Centers, which serves Hispanic population at the Indian Chicano Center in Omaha;
- Lincoln-Lancaster County Health Department, which targets Medicaid and underserved persons with diabetes in the 15 county CATCH network.

Desired Impact Objective: To provide education and prevention services to people from two rural counties who have diabetes or who are at risk of developing diabetes, with emphasis on the Hispanic population, by September 30, 2009.

Annual Activity Objective: Subawardee will conduct at least 52 weekly group classes in two rural counties to support weight loss, enroll individuals in physical activity training and testing, and provide individual diabetes management sessions to 90 persons with diabetes, by September 30, 2006.

Desired Impact Objective: To maintain additional fruit and vegetable consumption (at least two daily servings of fruit and at least two daily servings of vegetables with one-third being dark or orange vegetables) and maintain physical activity participation (30 minutes a day on 5 or more days of the previous 7 days) among Native American children at the Santee Sioux School, by September 30, 2009

Annual Activity Objective: Subawardee will contract with the Santee

School to provide learning experiences and serve fruit and vegetable snacks to children in the morning and afternoon, and provide physical activity classes, extra physical activity events and activities, by September 30, 2006.

Essential Service 7 - Link people to services:

Desired Impact Objective: To improve referral services for adults with diabetes, enrolled in community-based programs, by September 30, 2009.

Annual Activity Objective: Subawardee will contract for patient services, by September 30, 2006:

- Panhandle Community Services (PCS), which serves Native Americans and Hispanics in Scotts Bluff County;
- Nebraska Medical Center Diabetes Program, which serves Hispanic clients at the Indian-Chicano Center in Omaha;
- Lincoln-Lancaster County Health Department, which targets Medicaid and underserved persons with diabetes in the 15 county CATCH network.

PROGRAM PROFILE

1. Program Title: DIABETES PROGRAM

2. Total Block Grant Funds to Program:

Current Year:	
a. HO 5-5	$56,757
Total:	$56,757

Prior Year:	
a. HO 5-5	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 5-5	$56,757
Total:	$56,757

4. Total FTE's for Program:

Number:	
a. HO 5-5	0.20
Total:	0.20

Description (Optional): The PHHS Block Grant supports four contracts for services to people with diabetes and high risk children, and a subgrant to a district health department-operated project for diabetes education primarily among the Hispanic population of two counties.

HEALTH OBJECTIVE PROFILE for HO 5-5 Diabetes

5a. National Health Objective: 5-5 Diabetes

Reduce the diabetes death rate
75 deaths due to diabetes reported as the underlying or multiple case of death per 100,000 population in 1997 (age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

To reduce the diabetes death rate to no more than 25.0 per 100,000 population, by September 30, 2010.

[Baseline: 50 per 100,000 population, age 18 and over, 1994 to 1998]
[This is an ambitious target rate, particularly for Native Americans, African Americans, and Hispanic Americans where mortality rates are especially high. The Target rate was set using the "better than the best" method suggested in the Healthy People 2101 documents, with Asian Americans having the "best" rate in Nebraska of 27.2 deaths per 100,000 population.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

To increase the proportion of adults with diabetes who have a glycosylated hemoglobin (Hemoglobin A1c) test performed annually to at least 50%, by September 30, 2010.

[Baseline: 27%, BRFSS Survey, persons aged 18 and older reporting ever having been diagnosed with diabetes, and report that a doctor, nurse or other health professional has checked the respondent's glycosylated hemoglobin in or more times in the past year.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)
[Update: According to the 1999 BRFSS, less one third of Nebraska survey responders with diabetes recalled having glycosylated hemoglobin or hemoglobin A1c test done in the past year.]

7a. Target and Disparate Population Numbers:

Target Number: 87,000
Disparate Number: 64,000

8a. HO Dollars/FTE's:

(1). Total Current Year: $56,757
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $56,757
(4). Number of FTE's for HO: 0.20
(5). Amount of $'s to Local Entities for HO: $56,757

Description (Optional): PHHS Block Grant funds are used to contract with providers that provide services aimed at minority and low-income persons with diabetes, to provide a preventive

nutrition/physical activity program for Native American children, and to support education services provided by a district health department aimed at the Hispanic population.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 5-5 10-49% - Partial source of funding

10a. Block Grant Role:

HO 5-5 Supplemental Funding

Description (Optional): The PHHS Block Grant supports a little over 9 percent of the NHHSS Nebraska Diabetes Control Program's total budget. The NDPCP will receive $315,279 from CDC during the their fiscal year March 2005 to March 2006. It is important to note that PHHS Block Grant funding is the only funding available to support direct patient services.

However, the PHHS Block Grant represents a major portion (50%) of the funds available for diabetes programing at the district health department, and 100% of the funds available to run the wellness center's exercise and weight management program for Hispanic people with diabetes.

11a. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 7 - Link people to services

State Program Title: EMERGENCY MEDICAL SERVICES TRAINING PROGRAM

State Program Strategy:

Nebraska recognizes how critical emergency medical services are to its citizens, particularly people who live in sparsely populated rural areas of the state.
The purpose of the Emergency Medical Services (EMS) Program is to maintain and improve the emergency medical care system in Nebraska, assuring quality care is available to all those who live in and travel through the state of Nebraska. This is accomplished through training, technical support and regulatory control of the emergency medical care system.

The primary strategy selected for the PHHSBG-funded EMS Program continues to be training, in order to ensure quality care and protect the safety of the EMS worker.

PHHS Block Grant funds are used to develop and implement new EMS curricula, to provide both inital training and continuing education, and to guide the 420 ambulance servces and nearly 9000 certified EMS personnel.

Funds are used to provide tuition reimbursement to Nebraska citizens who attend training, which assures an adequate number of certified emergency medical providers in the state. (Tuition provided for EMT Training = $360 per person, EMT/First Responder Refresher Training = $90 per person and inital First Responder Training = $125 per person.) Since the majority of those who trained are volunteers, the reimbursement of training costs is critical to the continued availability of personnel to provide pre-hospital services.

Nebraska's Emergency Medical Services (EMS) System works to ensure public access, communication, transportation and high-quality emergency care. Ambulance and rescue services respond to about 100,000 calls per year all across the state -- from the most remote rural areas, from residents of Nebraska's Indian Reservations, and from heavily populated urban areas.

The Nebraska EMS System provides technical and skills training for both in-hospital and out-of-hospital personnel, including emergency medical technicians (EMTs), nurses, physicians. A wide variety of training courses and classes are conducted in the areas of trauma care, pediatric care, geriatric care, and cardiac care.

To assure quality services, training is provided and manuals are distributed as part of the EMS Quality Improvement Program, and classes are held in Emergency Vehicle Operations. To protect providers, classes are held on Infection Control, Extrication, Hazardous Materials, Patient Lifting and Moving for each NHHSS-EMS Program Region.

The EMS System carries out data surveillance functions, including the Nebraska Ambulance and Rescue Service Information System (NARSIS) and the Crash Outcome Data Evaluation System (CODES).

The EMS System also carries out planning and administrative functions, addressing culture and language issues like recruitment and retention of Hispanic providers and exploring the use of distance learning and internet based education.

Levels of Certification:
The State of Nebraska has four levels of certification for out-of-hospital providers they are: First Responders (FR), Emergency Medical Technician (EMT), Emergency Medical Technician-Intermediate (EMT-I) and Emergency Medical Technician-Paramedic (EMT-P). These professionals are dedicated to the emergency medical care that makes the emergency medical system of Nebraska work.

Out-of-hospital service providers need a destination for their patients. Creating strong relationships between health care facilities and the local out-of-hospital provider is key to maintaining a viable health care system. The EMS Program and staff supports quality assurance efforts, education programs and many other activities in support of hospitals and their personnel.

In order to become an out-of-hospital provider in Nebraska, an individual must successfully complete the course and certification requirements of each of these levels. For more information on how to become a certified out-of-hospital provider contact one of the Regional EMS Specialists.
[Source: NHHSS website, EMS page]

National Health Objective: HO 1-11 Emergency Medical Services

State Health Objective(s):

To maintain in Nebraska, an emergency medical service (EMS) and trauma system linking pre-hospital, hospital, and rehabilitation services in order to prevent deaths and long-term disability, and benefiting particularly Nebraska's 90 non-metropolitan counties, by September 30, 2010.

State Health Problem:

Everyone needs to have access to quality health care services in order to help eliminate health disparities and increase the quality of life for all Americans. Clinical preventive care, primary care, **emergency services**, long-term and rehabilitative care, and tertiary care services such as hospital and specialty care are all necessary parts of the continuum of care. Access to all of these components of the health care system is needed so that everyone can receive high quality health care services.

Emergency Services:
Pre-hospital emergency medical services (EMS), poison control centers, and hospital-based emergency departments are the most commonly sought sources of emergency medical care. For millions of Americans, these sources provide first-contact care. For injured or severely ill persons, they form the necessary link between the onset of symptoms or injury and treatment in the hospital. For individuals who have less severe health problems but believe they need immediate care, these services form the gateway to additional care.
[Adapted from: "Nebraska 2010 Health Goals and Objectives", published May 2002]

In many Nebraska counties, the Emergency Medical Services (EMS) System provides the only link to medical care for the people of the county. The availability of emergency medical services must be maintained, quality of care must be continually improved through updating the education of the people providing the care.

About 100,000 ambulance runs are made in response to calls for emergency assistance in Nebraska each year. It is estimated that the average Nebraskan will ride in an ambulance 2.5 times in their life. [Source: EMS program staff, August 2000]

Among the challenges faced by Nebraska in assuring adequate emergency medical services are:

⏩ Large geographic area. Nebraska's total area, including land and water is 77,358 square miles, ranking it as the 16th largest state. Nebraska's land area alone is 76,878 square miles, ranking it the 15th largest state.
⏩ Uneven population distribution. More than three-fourths of Nebraska's population lives in the eastern third of the state. More than half of the population lives in Nebraska's six largest counties. (Nebraska 2000 Census estimate 1,711,263)
⏩ Sparsely populated counties. Many central and western Nebraska counties are sparsely populated.

According to 2000 Census figures, 33 of Nebraska's 93 counties had fewer than 6 people per square mile, designating them as "frontier" counties. Additionally,19 counties had between 6 and 12 people per square mile, and 22 counties had between 13 and 24 people per square mile. Only 19 counties had 25 or more people per square mile . Of the most populous 19 counties, only four had more people per square mile than the United States as a whole. Nebraska as a whole had 22.3 people per square mile, compared to 79.6 people per square mile in the United States as a whole.

Target Population:

Nebraska defines the Target Population to include all emergency medical personnel, eligible for training and, through them, all persons receiving services each year.

The number for the Target Population is based on the 420 licensed ambulance services and nearly 9,000 certified ambulance attendants and the 100,000 people served each year.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population a portion of the people who live in the rural areas of the state.

There were 874,792 rural residents of Nebraska, who represented 51.1 percent of the statewide population (1,711,263), according to 2000 U.S. Census figures. Of Nebraska's 93 counties, 89 have less than 50,000 residents and 74 have 24 or fewer people per square mile.

The rural areas of the state have the greatest need for Emergency Medical Services, as explained in the Health Problem Description section of this Application.

The number in the Disparate Population was estimated based on the number rural residents and the average annual number of of EMS runs (100,000). Among the highest risk population are coronary event victims and trauma/injury victims, of all ages across the state.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 8 - Assure competent workforce:

Desired Impact Objective: To assure availability of quality EMS services to the citizens of Nebraska, by providing initial and follow-up training, which meets 1994 National Standards for both curriculum and certification, to in-hospital and out-of-hospital care providers in all 93 Nebraska counties, by September 30, 2009.

Annual Activity Objective: Subawardee will provide training to 400 people in initial EMT courses, 300 people in certified EMT courses and 50 people in First Responder courses, by September 30, 2006.

Annual Activity Objective: Subawardee will conduct training for 1,000 emergency medical services personnel on safety issues, by September 30, 2006.

Annual Activity Objective:
In collaboration with the Office of Minority Health, conduct a survey among Nebraska's emergency medical services providers to determine common disparate cultures and languages encountered and identify needs to provide equal care to all people, by September 30, 2006.

National Health Objective: **HO 23-5 Data and Information systems**

State Health Objective(s):

To maintain and improve Nebraska's emergency medical services surveillance system, in order to improve quality of care given, by September 30, 2010.

The Nebraska Ambulance and Rescue Squad Information System (NARSIS) collects and processes patient care information from pre-hospital care providers for use in their education, both basic and advanced levels, and to address treatment quality improvement issues.

E-NARSIS

During FY2005, the EMS Program began introducing a new technology to document care given -- called E-NARSIS. The computer-based data reporting system was piloted from November 2004 through April 2005 in 13 ambulance services across the state. Since then other ambulance services have been trained in the use of the system, designed to make submitting information about emergency health services rendered quicker, more accurate and more complete. As of the end of FY2005, 167 ambulance serices had been trained.

Uses for Reports

Through the service-specific NARSIS report, the rescue units are able to determine their strengths and weaknesses in documentation of patient care. Reports are provided to EMS instructors, EMS regional coordinators, and the Medical Directors of specific ambulance services. The NARSIS data are used in EMS planning and as another source of data for Crash Outcome Data Evaluation System (CODES) and injury analysis. Information is also provided to NHHSS staff, including the Office of Rural Health, Office of Minority Health and Injury Program.

Documentation helps protect ambulance services from litigation by documenting care provided, and is just as necessary, valuable and vital to the patient's care as treating the injury, or providing any other element of care. Documentation is part of proper patient care.

State Health Problem:

There is a need to document ambulance services rendered throughout Nebraska in order to improve the quality of emergency health care.

In many Nebraska counties, the Emergency Medical Services (EMS) System provides the only link to medical care for the people of the county. The availability of emergency medical services must be maintained, quality of care must be continually improved through updating the education of the people providing the care.

About 100,000 ambulance runs are made in response to calls for emergency assistance in Nebraska each year. It is estimated that the average Nebraskan will ride in an ambulance 2.5 times in their life. [Source: EMS program staff, August 2000]

Target Population:

Nebrasaka defines its Target Population as the potential users of the data produced (estimated number).

Those users are the administrators of the EMS Program at the state level, the local level ambulance services, and the EMS trainers and EMS training institutions.

Group(s) Served: State Health Department, Health Care Delivery Organizations, Fire, Police, Safety Organizations, Other

Disparate Population:

Nebraska defines its Disparate Population as the same as its target population.

Group(s) Served: State Health Department, Health Care Delivery Organizations, Fire, Police, Safety Organizations, Other

ESSENTIAL SERVICES

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To maintain the Nebraska Ambulance and Rescue Service Information System (NARSIS) to identify and evaluate the type and quality of EMS services rendered across the state, by September 30, 2009.

Annual Activity Objective: Subawardee will receive and enter paper patient care forms and will receive electronically submitted (E-NARSIS) patient care forms from pre-hospital care providers, work to ensure complete and accurate information, process about 100,000 forms, by September 30, 2006.

Annual Activity Objective: Subawardee will analyze data to identify state-level trends in health emergency care delivery and provide reports of region and service-specific effectiveness of documentation, in order to improve patient outcomes, by September 30, 2006.

PROGRAM PROFILE

1. Program Title: EMERGENCY MEDICAL SERVICES TRAINING PROGRAM

2. Total Block Grant Funds to Program:

Current Year:	
a. HO 1-11	$314,385
b. HO 23-5	$50,706
Total:	$365,091

Prior Year:	
a. HO 1-11	$46,174
b. HO 23-5	$0
Total:	$46,174

3. Total Block Grant Funds to Local Entities for Program:

a. HO 1-11	$47,795
b. HO 23-5	$0
Total:	$47,795

4. Total FTE's for Program:

Number:	
a. HO 1-11	4.84
b. HO 23-5	1.50
Total:	6.34

Description (Optional): PHHS Block Grant funds supply almost half of the personnel cost for each of 11 EMS Program staff positions, including the director, project coordinator, support staff, and training and trauma specialists, stationed in the Lincoln, Norfolk, Kearney and North Platte offices.

HEALTH OBJECTIVE PROFILE for HO 1-11 Emergency Medical Services

5a. National Health Objective: 1-11 Emergency Medical Services

Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.
An operational definition has not been specified.

6a. State Health Objective(s):

To maintain in Nebraska, an emergency medical service (EMS) and trauma system linking pre-hospital, hospital, and rehabilitation services in order to prevent deaths and long-term disability, and benefiting particularly Nebraska's 90 non-metropolitan counties, by September 30, 2010.

7a. Target and Disparate Population Numbers:

Target Number: 108,000
Disparate Number: 60,000

8a. HO Dollars/FTE's:

(1). Total Current Year: $314,385
(2). Total Prior Year: $46,174
(3). Amount to Disparate Population: $180,000
(4). Number of FTE's for HO: 4.84
(5). Amount of $'s to Local Entities for HO: $47,795

- Description (Optional): One PHHSBG subawarded ($47,795) is used for reimbursement of initial training costs to the local providers of emergency medical service.
- Another subaward ($312,764) supports NHHSS EMS staff (Administrator, Project Coordinator, Support Staff, and EMS Specialists), their travel costs and the cost of providing training sessions.
- A third subaward ($50,706) supports the data surveillance system specific to the provision of emergency medical services in Nebraska.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 1-11 10-49% - Partial source of funding

10a. Block Grant Role:

HO 1-11 Supplemental Funding

Description (Optional): The PHHS Block Grant supports 27.4% of the Nebraska's EMS functions overall.

The primary use of PHHSBG funds is to help carry out both initial and follow-up training for EMS providers.

In addition, PHHSBG funds support all Nebraska Ambulance and Rescue Squad Information System (NARSIS) activities. NARSIS gathers data directly from service providers, based on reports made about each ambulance run made during the year. The information is used to improve the quality of training and therefore the quality of emergency care given.

This year, in collaboration with the Office of Minority Health, the EMS Program will conduct a survey among Nebraska's emergency medical services providers to determine common disparate cultures and languages encountered and identify needs to provide equal care to all people.

Other sources of funding for the EMS System:

The EMS System has about $1.5 million available each year to carry out traditional EMS functions.

- Staff of the Nebraska Health and Human Services System (NHHSS) and its partners worked for many years to both maintain quality services and seek additional state funding. In 2001, the Nebraska Legislature approved expanded financial support, through a fee on each motor vehicle license. The "50 Cents Per life" fee generates about $900,000 per year, to support basic training for EMTs and first responders, instructor training, prevention activities, expansion of data surveillance, and implementation and administration of an expanded statewide Trauma System.

- State General funds dollars, totaling about $600,000 per year, to support the EMS System and its various programs, including training, trauma system, and credentialing activities, the Critical Incident Stress Management Program, and the Crash Outcome Data Evaluation System (CODES)data system.

- The EMS Program also receives EMSC and AED funds.

Not included in the total above are Trauma funds and Critical Access Hospital funds.

11a. 10 Essential Services

Essential Service 8 - Assure competent workforce

HEALTH OBJECTIVE PROFILE for HO 23-5 Data and Information systems

5b. National Health Objective: 23-5 Data and Information systems

Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data - especially for select populations - are available at the Tribal, State, and Local levels.
An operation definition has not been specified.

6b. State Health Objective(s):

To maintain and improve Nebraska's emergency medical services surveillance system, in order to improve quality of care given, by September 30, 2010.

The Nebraska Ambulance and Rescue Squad Information System (NARSIS) collects and processes patient care information from pre-hospital care providers for use in their education, both basic and advanced levels, and to address treatment quality improvement issues.

E-NARSIS

During FY2005, the EMS Program began introducing a new technology to document care given -- called E-NARSIS. The computer-based data reporting system was piloted from November 2004 through April 2005 in 13 ambulance services across the state. Since then other ambulance services have been trained in the use of the system, designed to make submitting information about emergency health services rendered quicker, more accurate and more complete. As of the end of FY2005, 167 ambulance serices had been trained.

Uses for Reports
Through the service-specific NARSIS report, the rescue units are able to determine their strengths and weaknesses in documentation of patient care. Reports are provided to EMS instructors, EMS regional coordinators, and the Medical Directors of specific ambulance services. The NARSIS data are used in EMS planning and as another source of data for Crash Outcome Data Evaluation System (CODES) and injury analysis. Information is also provided to NHHSS staff, including the Office of Rural Health, Office of Minority Health and Injury Program.

Documentation helps protect ambulance services from litigation by documenting care provided, and is just as necessary, valuable and vital to the patient's care as treating the injury, or providing any other element of care. Documentation is part of proper patient care.

7b. Target and Disparate Population Numbers:

Target Number: 5,000
Disparate Number: 5,000

8b. HO Dollars/FTE's:

(1). Total Current Year: $50,706
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $50,706
(4). Number of FTE's for HO: 1.50
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): Funds are used to support data processing staff at the state level.

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-5 10-49% - Partial source of funding

10b. Block Grant Role:

HO 23-5 Supplemental Funding

Description (Optional): PHHS Block Grant funds are a major source of funding for the NARSIS data system.

PHHSBG support the collection and analysis of data about the emergency medical services provided.

The administrative portion of NARSIS (1 FTE) is supported by the state generated "50 cents per life" fee on motor vehicle licenses.

11b. 10 Essential Services

Essential Service 9 - Evaluate health programs

State Program Title: INJURY AND VIOLENCE PREVENTION PROGRAM

State Program Strategy:

⃠ The Nebraska Health and Human Services System (NHHSS) carries out activities with partners in order to prevent both intentional and unintentional injury and reduce the incidence and severity of injury in Nebraska.

⏩ **Strategies selected for the PHHSBG-funded Injury and Violence Prevention Program include planning and provision of community education, surveillance, training, victim services and technical assistance.**

The PHHS Block Grant funded Injury and Violence Prevention Program helps support child passenger safety training and child safety seat check-up events to assure proper use; education and planning for prevention of falls, surveillance of deaths among children and youth, prevention of alcohol related automobile crashes among youth, and sexual assault education for prevention and services for victims.

NHHSS Programs and Services:

Injury Prevention & Control Program

- Injury Program staff provide technical support to over 300 Child Passenger Technicians across Nebraska, and to local health departments and SAFE KID Coalition and Chapters, as well as Safe Communities teams across the state.
- Injury Program staff conduct training and safety seat check events, provide education through the media, monitor subgrants and respond to calls from the public.

Nebraska Child Death Review Team

- Injury Program Staff serve on the Child Death Review Team.

A total of 1,845 children and youth, newborn through 17 years of age died in Nebraska between 1996 and 2001. The Nebraska Child Death Review Team looked at available information about those deaths and made recommendations based on the review and analysis. The recommendations focused on specific causes of death judged to be preventable. The Nebraska Child Death Review Team issued a report in July 2004, covering the 1996 to 2001 period.

National Health Objective: HO 15-6 Child fatality review

State Health Objective(s):

To reduce the infant mortality rate to no more than 4.5 per 1,000 live births, by September 30, 2010. *[Baseline: 6.8 per 1,000 live births]*

To reduce the neonatal death rate to no more than 2.9 per 1,000 live births, by September 30, 2010. *[Baseline; 4.5 per 1,000 live births]*

To reduce the postneonatal death rate to no more than 1.2 per 1,000 live births, by September 30, 2010. *[Baseline: 2.3 per 1,000 live births]*

To reduce the child death rate (aged one to four years) to no more than 17.4 per 100,000 population, by September 30, 2010. *[Baseline: 32.3 per 100,000 population]*

To reduce the child death rate (aged five to 9 years) to no more than 13.1 per 100,000 population, by September 30, 2010. *[Baseline: 18.8 per 100,000 population]*

To reduce the child death rate (aged 10 to 14 years) to no more than 18.0 per 100,000 population, by September 30, 2010. *[Baseline: 23.7 per 100,000]*

(These objectives are taken from "Nebraska 2010 Health Goals and Objectives", published May 2002.)

State Health Problem:

Infant Deaths:

- A total of 178 infant deaths occurred among Nebraska residents in 2002, which translates into an infant mortality rate of 7.0 per 1,000 live births. This figure represents a slight increase from the infant mortality rate of 6.8, which tied the 1999 figure as the lowest infant mortality rate ever recorded in Nebraska's history. As in recent years, the two leading causes of infant deaths in Nebraska in 2002 were birth defects and Sudden Infant Death Syndrome (SIDS), which accounted for 42 and 18 infant deaths, respectively. Low birth weight babies accounted for 118 (66.3%) of Nebraska's infant deaths, with 90 of these children falling into the very low birth weight (below 1500 grams) category. Neonates (infants less than 28 days old) accounted for about two-thirds of Nebraska's 2002 infant deaths, with a count of 121, while post-neonates (infants between 28 days and one year of age) accounted for the remaining 57 deaths.

[Source: Nebraska Vital Statistics Report, 2002, published by the NHHSS]

- A total of 141 infant deaths occurred among Nebraska residents in 2003, which translates into an infant mortality rate of 5.4 per 1,000 live births. This figure represents a substantial decrease from the 2002 rate, and is the lowest infant mortality rate ever recorded in the state's history. As in recent years, the two leading causes of infant deaths in Nebraska in 2003 were birth defects and Sudden Infant Death Syndrome (SIDS), which resulted in 36 and 24 infant deaths respectively. Low birth weight babies accounted for 88 (62.4%) of Nebraska's infant deaths, with 68 of these children falling into the very low birth weight (<1500 grams) category. Neonates (infants less

than 28 days old) accounted for about two-thirds of Nebraska's 2003 infant deaths, with a count of 96, while post-neonates (infants between 28 days and one year of age) accounted for the remaining 45.

[Source: Nebraska 2003 Vital Statistics Report, published August 2004 by NHHSS]

Child Deaths:

Child and adolescent mortality rates in the United States have generally declined over the past two decades. Rates for children one to four years of age and five to nine years of age have generally declined in the past decade. For children and adolescents in the two middle age brackets (10-4 and 15-19) death rates have been relatively stable in Nebraska.

In 2003, the leading causes of death among males aged 1 to 19 years of age :

- Accidents (unintentional injury) -- 53 deaths,
- Suicide -- 16 deaths
- Birth defects -- 7 deaths
- Cancer -- 7 deaths

In 2003, the leading causes of death among females aged 1 to 19 years of age were:

- Accidents (unintentional injury) -- 30 deaths
- Homicide -- 6 deaths
- Birth defects -- 5 deaths

[Source: "Vital Statistics Report, 2003", NHHSS, printed August 2004.]

Death Rates by Age

	1995-1999	1999-2003
Infants (per 1,000 live births)	6.8	6.6
Neonatal -- within first 28 days (per 1,000 live births)	4.5	4.5
Postneonatal -- 28 days to 1 year (per 1,000 live births)	2.3	2.1
Children -- one to four years (per 100,000 population)	32.3	34.2
Children -- five to nine years (per 100,000 population	18.8	18.7
Adolescents -- ten to fourteen years (per 100,000 population)	23.7	19.9
Adolescents -- fifteen to nineteen years (per 100,000 population)	74.0	70.8

Target Population:

Nebraska defines the Target Population as the number persons under the age of 14 years.

[Source: US Census 2000 -- projections for July 2005]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years, 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as the same as the Target Population.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years, 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: To monitor routinely collected vital statistics, case records and other data to understand the causes of death among Nebraska's children, by September 30, 2009.

Annual Activity Objective: Subawardee will serve on the Child Death Review Team, which will collect and study vital records for the purpose issuing a report of findings and recommendations, by September 30, 2006.

National Health Objective: **HO 15-13 Unintentional injury deaths**

State Health Objective(s):

To reduce the death rate due to unintentional injuries to no more than 19.4 per 100,000 population, by September 30, 2010.

[Baseline: 38.8 deaths per 100,000 population, 1998]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002 by NHHSS)

State Health Problem:

Injury Problem in Nebraska

- Injury is a major public health problem in Nebraska. Injuries are one of the leading causes of death for Nebraskans of all ages, regardless of gender, race or economic status.
- Unintentional and intentional injuries are the leading cause of years of life lost for Nebraskans.
- In Nebraska, falls are the leading causes of all injury hospitalizations and outpatient visits.
- Falls are the second leading cause of unintentional injury deaths. Motor vehicle crashes are the leading cause of death for persons ages 4 through 33 years.

[Source: NHHSS Website, Injury Prevention and Control Program page, current Oct 2005]

Unintentional Injury was the 5th leading cause of death in Nebraska during 2003, responsible.for 695 deaths.

- Motor-vehicle crashes were once again Nebraska's leading cause of unintentional deaths, accounting for 306 fatalities.
- Falls remained the state's number 2 cause of unintentional deaths, with 136 fatalities in 2003.
- Twenty-one of the state's unintentional deaths in 2003 were farm-related.
- Unintentional injuries were the leading cause of deaths in 2003 among Nebraska residents under the age of 45 years (excluding infants under one year of age), accounting for 275 (32.1%) of 858 deaths.

	1999	2000	2001	2002	2003
Number	665	637	630	754	695
Rate	36.6	34.7	34.5	41.3	38.2

Age-adjusted rates per 100,000 population

[Source: Nebraska 2003 Vital Statistics Report, published Aug 2004]

Consequences:

- Injury deaths are only part of the picture. Many Nebraskans are injured each year and survive. For many of them, the injury causes temporary pain and inconvenience, but for some, the injury leads to disability, chronic pain, large medical bills, and profound change in lifestyle.
- Unintentional Injury caused a total 15,127 years-of-potential-life-lost, or 15.1% of the the total years-of-potential-life-lost in Nebraska in 2000. Suicide caused an additional 6,127 years-of-potential-life-lost. Of all injury causes, motor vehicle/traffic related injuries were the leading cause of years-of-potential-life lost, accounting for 9,562 years-of-potential-life-lost.

- In Nebraska, falls are the leading cause of all injury hospitalizations and outpatient visits. Falls rank second only to motor vehicle fatalities as ta cause of unintentional deaths. Males and females age 85 and over have the highest rate of fall injuries. Rates increase dramatically beginning at age 65. Males age 1 to 4 years also experience high rates of fall injuries.
- Motor Vehicle crashes are the leading cause of death for persons ages 4 through 33 years. During 2001, 246 persons died and 26,751 were injured in traffic crashes in Nebraska.

[Source: "Nebraska Injury Prevention Plan", published 2004 by the NHHSS.]

Overview of **Youth** Deaths and Injuries:

- There were a total of 1,992 injury deaths in Nebraska from 1999 to 2001, including 172 youth age 14-19 that accounted for 8.6% of total injury deaths. Of these 172 deaths, most of them (76.2%) were caused by motor vehicle crashes.
- Struck by or against an object, falls, and motor vehicle crashes are the three leading causes of injuries among youth (14-19) in Nebraska.

Behaviors that contribute to **unintentional** injuries:

- One quarter of students (25%) reported "always" wearing seat belts when riding in a car driven by someone else; almost 29% of students said they wore seat belts "most of the time". Close to a quarter of students (24%) "sometimes", 17% of students "rarely", and 6% "never" wore seat belts when riding in a car driven by someone else
- One-fourth of students reported they rode motorcycles during the past 12 months. Most riders were males (66%). Among students who rode motorcycles during the past 12 months:
  - Despite the helmet law, less than half of students (42%) always wore a helmet when riding motorcycles while 34% of students never or rarely wore a motorcycle helmet.
  - Males (42%) were more likely than females (22%) never to wear a helmet or to rarely use a helmet. Overall, 32% of 9th, 40% of 10th, 33% of 11th, and 35% of 12th graders never or rarely wore a helmet when they rode a motor
- Overall, 66% of students had ridden a bicycle during the 12 months preceding the survey. Male students (70%) were slightly more likely than female students (63%) to ride bicycles. Students who rode a bicycle declined with grade level, from 79% of 9th graders to 60% of 12th graders. This may be because older students drive cars instead of riding bicycles
- Of the students who rode bicycles, 93% rarely or never wore a bicycle helmet; 92% of females and 94% of males rarely or never wore a helmet when riding on a bike. Eighty six percent of 9th, 96% of 10th, 97% of 11th, and 95% of 12th graders never or rarely wore a bicycle helmet.
- Forty three percent of students rode one or more times during the 30 days preceding the survey in a car or other vehicle driven by someone who had been drinking alcohol.
- A quarter (25%) of students had driven a car or other vehicle at least once after drinking alcohol during the 30 days preceding the survey. More males (29%) than females (21%) had driven a motor vehicle after drinking. A significant increase for drinking and driving was observed as grade level increased, from 7% for 9th graders to 38% for 12th graders.

[Source: Nebraska Surveillance Report: YRBS, published August 2004, NHHSS]
The YRBS is a self-administered, school-based survey for students in grades 9-12. The YRBS has been completed seven times in Nebraska during the spring semester: 1991, 1993, 1995, 1997, 1999, 2001, and 2003. YRBS is based on the self-reported health behaviors of a random sample of youth. This report presents results of data from 1991 to 2001.

Target Population:

Nebraska defines Target Population as adults aged 65 and older and children under the age of 15 years.

Projected census data, June 2005: 342,7738 people under the age of 14 and 233,233 people aged 65 and older.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years, 4-11 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population to be children under the age of 15 years.

Projection for June 2005 based on 2000 census data: 342,738 people under the age of 14.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years, 4-11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To maintain an educational program which addresses the leading causes of injury deaths and years-of-potential-life-lost, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will provide technical assistance and education aimed at highest risk age and cause categories and work with state and local level agencies to reduce unintentional injuries, by September 30, 2006.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain partnerships with agencies and organizations involved in injury prevention/interventions, by September 30, 2009.

> **Annual Activity Objective:** Subawardees will communicate with, and provide technical assistance and financial support to community organizations, state agencies and other partners in order to implement effective unintentional injury prevention programs, by September 30, 2006.

National Health Objective: HO 15-20 Child restraints

State Health Objective(s):

To increase the proportion of Nebraska children under the age of five years, who always use a child restraint when riding in a motor vehicle to no less than 100 percent, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002. The same document suggests that 80 percent might be a more reasonable objective for Nebraska, based on the observational survey results)

[Baseline: In 1997, the Nebraska BRFSS found 93 percent of adult respondents from households with the oldest child four years old or younger, reported that this child is always buckled into a car safety seat. Reported prevalence has remained steady since 1993. Note that this self-reported prevalence is significantly higher than the 66 percent recorded in 2000 observational survey.]

[Source: "Nebraska 2010 Health Goals and Objectives", published May 2002.]

State Health Problem:

Motor Vehicle Traffic Injury:
The age-adjusted injury hospital discharge rate for motor vehicle traffic was 684 per 100,000 population for the 1999-2003 period.
[Source: Injury in Nebraska, draft publication October 2005]

Unintentional Injury was the 5th leading cause of death in Nebraska during 2003, responsible.for 695 deaths. However, it was the leading cause of death among males and females age 1 to 44 years.

Age-adjusted death rate per 100,000 population:
1999 -- 36.6 2002 -- 41.3 2000 -- 34.7 2003 -- 38.2 2001 -- 34.5

Intentional Injury, including assault (homicide) and intentional self harm accounted for a total of 238 deaths in Nebraska in 2003.

Homicide:
Age-adjusted death rate per 100,000 population:
1999 -- 3.5 2000 -- 3.7 2001 -- 2.6 2002 -- 2.9 2003 -- 3.7

Suicide:
Age-adjusted death rate per 100,000 population:
1999 -- 10.4 2000 -- 11.1 2001 -- 10.9 2002 -- 11.8 2003 -- 10.1

[Source: Nebraska 2003 Vital Statistics Report, published Aug 2004]

Consequences:

- Injury deaths are only part of the picture. Many Nebraskans are injured each year and survive. For many of them, the injury causes temporary pain and inconvenience, but for some, the injury leads to disability, chronic pain, large medical bills, and profound change in lifestyle.

- Unintentional Injury caused a total 15,127 years-of-potential-life-lost, or 15.1% of the the total years-of-potential-life-lost in Nebraska in 2000. Suicide caused an additional 6,127 years-of-potential-life-lost. Of all injury causes, motor vehicle/traffic related injuries were the leading cause of years-of-potential-life lost, accounting for 9,562 years-of-potential-life-lost.
- In Nebraska, falls are the leading cause of all injury hospitalizations and outpatient visits. Falls rank second only to motor vehicle fatalities as ta cause of unintentional deaths. Males and females age 85 and over have the highest rate of fall injuries. Rates increase dramatically beginning at age 65. Males age 1 to 4 years also experience high rates of fall injuries.
- Motor Vehicle crashes are the leading cause of death for persons ages 4 through 33 years. During 2001, 246 persons died and 26,751 were injured in traffic crashes in Nebraska.

[Source: "Nebraska Injury Prevention Plan", published 2004 by the NHHSS.]

Overview of **Youth** Deaths and Injuries:

- There were a total of 1,992 injury deaths in Nebraska from 1999 to 2001, including 172 youth age 14-19 that accounted for 8.6% of total injury deaths. Of these 172 deaths, most of them (76.2%) were caused by motor vehicle crashes.
- Struck by or against an object, falls, and motor vehicle crashes are the three leading causes of injuries among youth (14-19) in Nebraska.

Behaviors that contribute to **unintentional** injuries:

- One quarter of students (25%) reported "always" wearing seat belts when riding in a car driven by someone else; almost 29% of students said they wore seat belts "most of the time". Close to a quarter of students (24%) "sometimes", 17% of students "rarely", and 6% "never" wore seat belts when riding in a car driven by someone else
- One-fourth of students reported they rode motorcycles during the past 12 months. Most riders were males (66%). Among students who rode motorcycles during the past 12 months:
  - Despite the helmet law, less than half of students (42%) always wore a helmet when riding motorcycles while 34% of students never or rarely wore a motorcycle helmet.
  - Males (42%) were more likely than females (22%) never to wear a helmet or to rarely use a helmet. Overall, 32% of 9th, 40% of 10th, 33% of 11th, and 35% of 12th graders never or rarely wore a helmet when they rode a motor
- Overall, 66% of students had ridden a bicycle during the 12 months preceding the survey. Male students (70%) were slightly more likely than female students (63%) to ride bicycles. Students who rode a bicycle declined with grade level, from 79% of 9th graders to 60% of 12th graders. This may be because older students drive cars instead of riding bicycles
- Of the students who rode bicycles, 93% rarely or never wore a bicycle helmet; 92% of females and 94% of males rarely or never wore a helmet when riding on a bike. Eighty six percent of 9th, 96% of 10th, 97% of 11th, and 95% of 12th graders never or rarely wore a bicycle helmet.
- Forty three percent of students rode one or more times during the 30 days preceding the survey in a car or other vehicle driven by someone who had been drinking alcohol.
- A quarter (25%) of students had driven a car or other vehicle at least once after drinking alcohol during the 30 days preceding the survey. More males (29%) than females (21%) had driven a motor vehicle after drinking. A significant increase for drinking and driving was observed as grade level increased, from 7% for 9th graders to 38% for 12th graders.

Behaviors that contribute to **intentiona**l injuries:

- Overall, 16% of students had carried a weapon at least once during the 30 days preceding the survey. Male students (29%) were much more likely than female students (3%) to have carried a weapon. Eighteen percent of 9th graders, 18% of 10th graders, 14% of 11th graders, and 12% of 12th graders carried a weapon such as gun, knife, or club during the past 30 days.
- More than a quarter (27%) of students were in a physical fight one or more times during the 12 months prior to the survey. Male students (35%) were more likely than female students (20%) to have reported that they were in a physical fight during the past 12 months. The percentage of students who were in physical fight decreased as grade level increased. Percentages reported were 34% in grade 9, 27% in grade 10, 25% in grade 11, and 22% in grade 12
- Nearly seven percent of students reported that their boy friends or girl friends hit, slapped, or physically hurt them on purpose during the 12 months preceding the survey. There was no significant difference between males (8%) and females (6%) that were hit by their boy friends or girl friends on purpose.
- Overall, 5% of students reported that they had ever been forced to have sexual intercourse when they did not want to. Female students (8%) were more than twice as likely as male students (3%) to have been forced to have sexual intercourse.
- Female students (22%) were more likely than male students (13%) to have seriously considered suicide during the past 12 months. Twenty two percent of 9th, 18% of 10th, 16% of 11th, and 15% of 12th graders reported that they seriously considered attempting suicide during the past 12 months

[Source: Nebraska Surveillance Report: YRBS, published August 2004, NHHSS]
The YRBS is a self-administered, school-based survey for students in grades 9-12. The YRBS has been completed seven times in Nebraska during the spring semester: 1991, 1993, 1995, 1997, 1999, 2001, and 2003. YRBS is based on the self-reported health behaviors of a random sample of youth. This report presents results of data from 1991 to 2001.

Target Population:

Nebraska defines the Target Population as the number of Nebraska children under the age of 5.

[Source: U.S. Census data for 2000]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as the number of children who do not always or almost always ride in proper restraints when riding in a car.

[Source: 1997-98 BRFSS Report]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To increase the correct installation and use of child safety restraints in cars to at least 98% among participants in child safety seat checkup events, by September 30, 2009.

Annual Activity Objectives: Subawardee will conduct at least two four-day-long National Highway Traffic Safety Administration (NHTSA) child passenger trainings with 25 participants, by September 30, 2006

Annual Activity Objective: Subawardee will conduct three four-hour-long child passenger trainings to communities across the state, by September 30, 2006.

Annual Activity Objective: Subawardee will sponsor child safety seat checkup events in three communities across the state, by September 30, 2006.

Annual Activity Objective: Subawardee will provide technical support the more thatn 300 Child Passenger Safety Technicians, by September 30, 2006.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain partnerships with agencies and organizations involved in child passenger safety, by September 30, 2009.

Annual Activity Objective: Subawardee will work with community organizations and agencies to improve knowledge and communication on issues surrounding correct and consistent child passenger safety restraint use, by September 30, 2006.

National Health Objective: **HO 15-27 Falls**

State Health Objective(s):

To reduce deaths due to falls to less than 3.5 per 100,000 population, by September 30, 2010.

(Baseline 6.9 deaths per 100,000 population, 1998)
[Source: Nebraska 2010 Health Goals and Objectives, published by NHHSS, May 2002]

State Health Problem:

Fall Injury:
The age-adjusted injury hospital discharge rate for falls was 2,184 per 100,000 population for the 1999-2003 period.
[Source: Injury in Nebraska, draft publication October 2005]

Unintentional Injury was the 5th leading cause of death in Nebraska during 2003, responsible.for 695 deaths. However, it was the leading cause of death among males and females age 1 to 44 years.

Age-adjusted death rate per 100,000 population:
1999 -- 36.6 2002 -- 41.3 2000 -- 34.7
2003 -- 38.2 2001 -- 34.5

Intentional Injury, including assault (homicide) and intentional self harm accounted for a total of 238 deaths in Nebraska in 2003.

Homicide:
Age-adjusted death rate per 100,000 population:
1999 -- 3.5 2000 -- 3.7 2001 -- 2.6
2002 -- 2.9 2003 -- 3.7

Suicide:
Age-adjusted death rate per 100,000 population:
1999 -- 10.4 2000 -- 11.1 2001 -- 10.9
2002 -- 11.8 2003 -- 10.1

[Source: Nebraska 2003 Vital Statistics Report, published Aug 2004]

Consequences:
- Injury deaths are only part of the picture. Many Nebraskans are injured each year and survive. For many of them, the injury causes temporary pain and inconvenience, but for some, the injury leads to disability, chronic pain, large medical bills, and profound change in lifestyle.
- Unintentional Injury caused a total 15,127 years-of-potential-life-lost, or 15.1% of the the total years-of-potential-life-lost in Nebraska in 2000. Suicide caused an additional 6,127 years-of-potential-life-lost. Of all injury causes, motor vehicle/traffic related injuries were the leading cause of years-of-potential-life lost, accounting for 9,562 years-of-potential-life-lost.
- In Nebraska, falls are the leading cause of all injury hospitalizations and outpatient visits. Falls rank second only to motor vehicle fatalities as ta cause of unintentional deaths. Males and females

age 85 and over have the highest rate of fall injuries. Rates increase dramatically beginning at age 65. Males age 1 to 4 years also experience high rates of fall injuries.

- Motor Vehicle crashes are the leading cause of death for persons ages 4 through 33 years. During 2001, 246 persons died and 26,751 were injured in traffic crashes in Nebraska.

[Source: "Nebraska Injury Prevention Plan", published 2004 by the NHHSS.]

Overview of **Youth** Deaths and Injuries:

- There were a total of 1,992 injury deaths in Nebraska from 1999 to 2001, including 172 youth age 14-19 that accounted for 8.6% of total injury deaths. Of these 172 deaths, most of them (76.2%) were caused by motor vehicle crashes.
- Struck by or against an object, falls, and motor vehicle crashes are the three leading causes of injuries among youth (14-19) in Nebraska.

Behaviors that contribute to **unintentional** injuries:

- One quarter of students (25%) reported "always" wearing seat belts when riding in a car driven by someone else; almost 29% of students said they wore seat belts "most of the time". Close to a quarter of students (24%) "sometimes", 17% of students "rarely", and 6% "never" wore seat belts when riding in a car driven by someone else
- One-fourth of students reported they rode motorcycles during the past 12 months. Most riders were males (66%). Among students who rode motorcycles during the past 12 months:
  - Despite the helmet law, less than half of students (42%) always wore a helmet when riding motorcycles while 34% of students never or rarely wore a motorcycle helmet.
  - Males (42%) were more likely than females (22%) never to wear a helmet or to rarely use a helmet. Overall, 32% of 9th, 40% of 10th, 33% of 11th, and 35% of 12th graders never or rarely wore a helmet when they rode a motor
- Overall, 66% of students had ridden a bicycle during the 12 months preceding the survey. Male students (70%) were slightly more likely than female students (63%) to ride bicycles. Students who rode a bicycle declined with grade level, from 79% of 9th graders to 60% of 12th graders. This may be because older students drive cars instead of riding bicycles
- Of the students who rode bicycles, 93% rarely or never wore a bicycle helmet; 92% of females and 94% of males rarely or never wore a helmet when riding on a bike. Eighty six percent of 9th, 96% of 10th, 97% of 11th, and 95% of 12th graders never or rarely wore a bicycle helmet.
- Forty three percent of students rode one or more times during the 30 days preceding the survey in a car or other vehicle driven by someone who had been drinking alcohol.
- A quarter (25%) of students had driven a car or other vehicle at least once after drinking alcohol during the 30 days preceding the survey. More males (29%) than females (21%) had driven a motor vehicle after drinking. A significant increase for drinking and driving was observed as grade level increased, from 7% for 9th graders to 38% for 12th graders.

Behaviors that contribute to **intentiona**l injuries:

- Overall, 16% of students had carried a weapon at least once during the 30 days preceding the survey. Male students (29%) were much more likely than female students (3%) to have carried a weapon. Eighteen percent of 9th graders, 18% of 10th graders, 14% of 11th graders, and 12% of 12th graders carried a weapon such as gun, knife, or club during the past 30 days.
- More than a quarter (27%) of students were in a physical fight one or more times during the 12 months prior to the survey. Male students (35%) were more likely than female students (20%) to

have reported that they were in a physical fight during the past 12 months. The percentage of students who were in physical fight decreased as grade level increased. Percentages reported were 34% in grade 9, 27% in grade 10, 25% in grade 11, and 22% in grade 12

- Nearly seven percent of students reported that their boy friends or girl friends hit, slapped, or physically hurt them on purpose during the 12 months preceding the survey. There was no significant difference between males (8%) and females (6%) that were hit by their boy friends or girl friends on purpose.
- Overall, 5% of students reported that they had ever been forced to have sexual intercourse when they did not want to. Female students (8%) were more than twice as likely as male students (3%) to have been forced to have sexual intercourse.
- Female students (22%) were more likely than male students (13%) to have seriously considered suicide during the past 12 months. Twenty two percent of 9th, 18% of 10th, 16% of 11th, and 15% of 12th graders reported that they seriously considered attempting suicide during the past 12 months

[Source: Nebraska Surveillance Report: YRBS, published August 2004, NHHSS]
The YRBS is a self-administered, school-based survey for students in grades 9-12. The YRBS has been completed seven times in Nebraska during the spring semester: 1991, 1993, 1995, 1997, 1999, 2001, and 2003. YRBS is based on the self-reported health behaviors of a random sample of youth. This report presents results of data from 1991 to 2001.

Target Population:

Nebraska defines Target Population as adults aged 65 and older and children under the age of 15 years.

Year 2000 census data: Nebraska had 369,427 people under the age of 15 and 232,195 people aged 65 and older.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population to be children under the age of 15 years.

Year 2000 census data: Nebraska had 369,427 people under the age of 15

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year, 1-3 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To reduce the rate of injury due to falls among children and older adults by 10%, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical assistance and support to SAFE KID coalitions and chapters to carry out fall injury prevention activities, by September 30, 2006.

Annual Activity Objective: Subawardee will analyze data and produce a report on data derived from inclusion of injury questions in the Behavioral Risk Factor Surveillance System (BRFSS) survey, by September 30, 2006.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain partnerships with agencies and organizations interested in being involved in fall injury prevention, by September 30, 2009.

Annual Activity Objective: Subawardee will work with community organizations and agencies to improve knowledge and communication on issues surrounding falls and fall prevention, by September 30, 2006.

National Health Objective: **HO 15-35 Rape or attempted rape**

State Health Objective(s):

To reduce the rate of rape and attempted rape among persons aged 12 years and older to no more than 0.2 per 1,000 population in Nebraska, by September 30, 2010.

[Baseline: 0.3 per 1,000 population in 1999 -- Based on the national survey, it is likely that the actual number of rapes and attempted rapes occuring in Nebraska is much higher]

(This objective was taken from the "Nebraska 2010 Health Goals and Objectives", published May 2002)

State Health Problem:

The U.S. Bureau of Justice Statistics' National Crime Victimization Survey (NCVS) reported that an estimated 200,880 rapes or attempted rapes occurred nationwide in 1999, for a rate of 0.9 per 1,000 persons aged 12 years and over. The NCVS collects data not only on crimes reported to police, but also on those that go unreported. It determined that little more than 28 percent of rapes and sexual assaults were actually reported to the police.

In Nebraska, law enforcement agencies reported a total of 413 forcible rapes in 1999 (0.3 per 1,000 persons age 12 and older). Based on results of the national survey, it is likely that the actual number of rapes and attempted rapes in Nebraska is much higher.
[Source: "Nebraska 2010 Health Goals and Objectives", published May 2003.]

One in eight adult women, or more than 84,000 adult women in Nebraska, have experienced one or more completed forcible rapes during her lifetime. (*Rape in Nebraska: A Report to the State, 2003,* Kirkpatrick & Ruggiero)

[Source: Nebraska Domestic Violence Sexual Assault Coalition]

In stating the extent of the problem of sexual assault, including rape, for Nebraska, limitations in existing data must be acknowledged:

⏩ The records of law enforcement agencies and local sexual assault programs give information about only a fraction of the number of Nebraskans probably affected by sexual assault/rape. Law enforcement data is limited by the narrow legal definition of rape and by how cases are handled by the criminal justice system. That limitation is compounded by substantial under-reporting. The National Women's Study found that 84% of rape victims do not report the incident to the police.

⏩ Local sexual assault center data reflect only the number of people who seek out the services of the centers.

⏩ Another source of data about sexual assault/rape for Nebraska is a telephone survey which yielded representative prevalence data for the first time. That data is limited in that it reached only those respondents who have phones and reflects only those who choose to participate in the survey and to disclose information about themselves.

⏩ None of these sources yield data about the incidence of sexual assault/rape in Nebraska. At this time, population-wide, representative sexual assault/rape incidence data are not available for Nebraska. *The health objective established for this section of the Application is necessarily based on incomplete knowledge of the extent of the problem of sexual assault/rape in Nebraska.*

Criminal Justice Data:
The Nebraska Commission on Law Enforcement and Criminal Justice publishes *Crime in Nebraska, Uniform Crime Report* . For 1998, 416 "forcible rapes" were reported by law enforcement agencies. The rate of reported rape for 1998 can be calculated to be 0.3 per 1,000 (or 30 per 100,000) population. However, *it should be noted the rate calculation is based on a narrow definition of the crime and is limited to only these women who chose to report their rape or attempted rape to law enforcement and where an arrest was made. The Uniform Crime Report "rape rate" therefore represents only a portion of the true incidence of rape in Nebraska.*

Forcible rape is defined by Nebraska law as the carnal knowledge of a female forcibly and against her will. Of these crimes reported in 1998, 360 (86.5%) were "rape by force" and 56 (13.5%) were "attempts to rape". Carnal abuse, without force (statutory rape) and all other sex offenses are not included in these figures.

Law enforcement agencies are asked to submit a supplementary report on the circumstances surrounding any rape by force or attempt to rape. Supplementary reports were received on only 237 cases, because the Omaha Police Department did not provide supplementary reports.

Victims under the age of 25 accounted for 68 percent of the total victims. Of those under 25, 35% were in the age group of 18 to 24 and 37% were in the age group of 11 to 15.

In defining Disparate Population, the National Crime Survey shows that young, unmarried and low-income women are the most frequent victims of rape and rape attempts. Other factors that probably also contribute to the likelihood of rape are previous history of rape, isolation and alcohol use.

Local Sexual Assault Center Data:
Another source of sexual assault/rape data is the Nebraska Domestic Abuse Sexual Assault Coalition, which compiles reports on people served by the local sexual assault centers of Nebraska. According to their reports, the following numbers of new adult sexual assault victims were served during the past few years:

	Forcible Rapes Reported
1998	450
1999	449
2000	513
2001	457
2002	489
2003	495
2004	597

These numbers represent only the victims who sought out the services of the local sexual assault centers during those years. Therefore, the true incidence of sexual assault/rape in Nebraska cannot be derived from those figures.

Target Population:

Nebraska defines Target Population as all females 11 to 29 years of age, living in Nebraska.

When selecting the *target audience*, partial reporting by Nebraska law enforcement agencies of the ages of victims for the past several years, shows that most victims are between 11 and 29 years of age (79.3% in 1993, 72.0% in 1994, 67.1% in 1995, 78.6% in 1996 and 73.6% in 1997.)

The percentage figures, above, do not include Omaha because the Omaha Police Department does not submit the supplementary reports which include the age of victims of rape and attempted rape. That lack of reporting means we do not know if the age group with the most victims in Omaha and Douglas County would be similar to that for the rest of the state.

According to "Census Estimates of Nebraska Population by Age", there were 235,643 females between the ages of 10 and 29 living in Nebraska in 1997, of which 66,357 lived in Douglas County. The number in the target population was selected based on the the victim age data outside Douglas County.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population as high risk females, 11 to 29 years of age. The figure is approximately 25% of the female population of that age group, who may be at higher risk because of their age, income, marital status and other contributing factors.

In defining *Disparate Population*, the National Crime Survey shows that young, unmarried and low-

income women are the most frequent victims of rape and rape attempts. Other factors that probably also contribute to the likelihood of rape are previous history of rape, isolation and alcohol use.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: To maintain the number of crisis intervention services provided to child, adolescent and adult victims of sexual assault, by September 30, 2009.

> **Annual Activity Objective for Desired Impact Objective:** Subgrantee will contract with 19 sexual assault/domestic violence programs across the state to respond to at least 6,600 sexual assault related crisis line calls, provide face-to-face services to 715 child, adolescent and adult victims and their supporting family members, and facilitate at least 770 support group sessions, by September 30, 2006.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To maintain the number of sexual assault prevention presentations provided to children, adolescents, young adults, parents and school personnel throughout Nebraska, by September 30, 2009.

> **Annual Activity Objective:** Subgrantee will will contract with 19 sexual assault/domestic violence programs across the state, plan and publicize presentations, train parent and teacher trainers, making at least 1,320 presentations to an audience of 39,820, by September 30, 2006.

These presentations will address a continuum of topics, including child sexual assault, sexual harrassment, sex offenders, acquaintance rape, dating violence, healthy relationships, prevention of sexual violence, men's role in ending violence against women, and gender issues. The programs will use preferred curricula such as "Step Up Speak Out" a web-based campaign geared towards young adults addressing dating violence, "Reaching and Teaching Teens to Stop Violence" both products of the Nebraska Domestic Violence Sexual Assault Coalition, in addition to other nationally published prevention materials.

National Health Objective: **HO 26-1 Alcohol and drug-related motor vehicle crashes**

State Health Objective(s):

To reduce deaths caused by alcohol-related motor vehicle crashes to no more than 4.0 per 100,000 population, by September 30, 2010.

[Baseline: 5.6 deaths per 100,000 population, 1998]
(Source: Nebraska 2010 Health Goals and Objectives, published May 2002 by NHHSS)

[Updated:

To reduce the rate of alcohol-related motor vehicle crashes to less than 10.3 per 100 million vehicle miles, by September 30, 2010.

[Baseline: 10.3 alcohol-related motor vehicle crashes per 100 million vehicle miles in 2004]
(Source: Highway Safety Program, Department of Motor Vehicles)

State Health Problem:

Alcohol Facts:

- Abuse of alcohol and illicit drugs contributes substantially to premature deaths by damaging health and triggering accidents.
- Health care costs are increased directly by treatment for alcoholism and drug dependency, and indirectly, by the adverse effects of chemical abuse on other medical conditions.
- Various societal problems such as domestic violence, child abuse, and school performance and behavior problems are linked to substance abuse in families.
- Alcohol-related traffic fatalities have decreased substantially over the past two decades. Various strategies to reduce drinking and driving may have had a major influence on this positive trend.
- Nebraska's death rates from alcohol-related traffic fatalities vary significantly across ethnic groups and suggest some areas for preventative efforts.
- Death rates from cirrhosis of the liver vary even more dramatically across Nebraska's various ethnic populations.
- Forty-six percent of Nebraska's high school students report that they have ridden in a vehicle with a driver who has been drinking in the past 30 days. This is well above the national average of 33 percent.
- Among high school seniors, Nebraska youth are more likely to drink alcohol than 12th graders nationwide. However, the opposite is true of illicit drugs. Among Nebraska seniors, 60 percent say they have never used illicit drugs, well above the nationwide rate of 46 percent, and even ahead of the national 2010 goal of 56 percent.
- Nebraska adolescents are much more likely to participate in "binge drinking" than their counterparts nationwide. Nebraska's study found over 40 percent of students in grades 9-12 participated in binge drinking in the past month.
- There are positive signs regarding substance abuse in America. Rates of usage have decreased noticeably over the past two decades, public awareness about dangers has increased and studies have demonstrated the effectiveness of prevention and treatment efforts.
- A 1999 federal study identified service system barriers to treatment as lack of qualified

professionals, the stigma attached to treatment, lack of insurance coverage, and inadequate reimbursement for clinically necessary services through public funding.

◆ The federal Substance Abuse and Mental Health Services Administration, with the Center for Substance Abuse Treatment, have embarked on the "National Treatment Plan" initiative to guide efforts to bring practice into line with research, improve service systems, develop qualified professionals and close treatment gaps.

Alcohol and Illicit Drug Use Among Adolescents:

Fewer Nebraska high-school seniors report that they never drink alcoholic beverages (14 percent) than do seniors nationwide (19 percent). The opposite is true, however, when high school seniors are asked if they have ever used any illicit drug Then, 60 percent of Nebraska seniors report such total abstinence versus only 46 percent nationally. *[Please note that the sources for national and Nebraska data differ. The national findings are based on the National Institute of Drug Abuse's (NIDA) "Monitoring the Future" study and the Nebraska findings are from the YRBS.]*

The 1998 National Household Survey on Drug Abuse reported that 79 percent of adolescents aged 12 to 17 had used no alcohol or illicit drug in the past 30 days. Nebraska's YRBSS, in 1999, found that only 41 percent of adolescents in grades 9 to 12 professed such an alcohol- and drug-free status for the past 30 days The national study included a younger cohort (12- and 13-year olds), but even as a "standalone statistic," Nebraska's finding that nearly 60 percent of our high school students used alcohol and/or some illicit drug in the past month deserves serious consideration.

Sixteen percent of Nebraska high school students reported using marijuana in the past 30 days, according to the 1999 YRBS. Prevalence of current use has risen since the 1993 survey, when nine percent stated they had used marijuana in the month prior to the survey.

Alcohol- and Drug-Related Motor Vehicle Fatalities:

The total number of traffic fatalities in the U.S. is only running a few hundred less per year than it was 20 years ago, but the proportion of those deaths attributed to alcohol use has dropped by nearly 10,000 lives per year. The number of alcohol-related traffic deaths dropped from 18,279 to 12,663 in just the nine-year period of 1990-1998. Diverse efforts in communities across the nation (including prompt license suspension, sobriety checks, zero tolerance for underage drivers, designated driver programs and other education efforts) may have contributed to this reduction.

Nebraska alcohol-related motor vehicle fatality rates have also declined over the last decade. Based on 1998 data, Nebraska's death rate from this cause was 5.6 per 100,000 population, compared to 5.9 nationally. While this may seem to make Nebraska's overall rate look acceptable, it should be noted that the death rates for various ethnic groups vary widely. The five-year average death rate for Native Americans was nearly twice that of whites.

[Source: *Nebraska 2010: Health Goals and Objectives,* published May 2002, NHHSS]

Overview of **Youth** Deaths and Injuries:

- There were a total of 1,992 injury deaths in Nebraska from 1999 to 2001, including 172 youth age 14-19 that accounted for 8.6% of total injury deaths. Of these 172 deaths, most of them (76.2%) were caused by motor vehicle crashes.
- Struck by or against an object, falls, and motor vehicle crashes are the three leading causes of

injuries among youth (14-19) in Nebraska.

Behaviors that contribute to **unintentional** injuries:

- One quarter of students (25%) reported "always" wearing seat belts when riding in a car driven by someone else; almost 29% of students said they wore seat belts "most of the time". Close to a quarter of students (24%) "sometimes", 17% of students "rarely", and 6% "never" wore seat belts when riding in a car driven by someone else
- One-fourth of students reported they rode motorcycles during the past 12 months. Most riders were males (66%). Among students who rode motorcycles during the past 12 months:
  - Despite the helmet law, less than half of students (42%) always wore a helmet when riding motorcycles while 34% of students never or rarely wore a motorcycle helmet.
  - Males (42%) were more likely than females (22%) never to wear a helmet or to rarely use a helmet. Overall, 32% of 9th, 40% of 10th, 33% of 11th, and 35% of 12th graders never or rarely wore a helmet when they rode a motor
- Overall, 66% of students had ridden a bicycle during the 12 months preceding the survey. Male students (70%) were slightly more likely than female students (63%) to ride bicycles. Students who rode a bicycle declined with grade level, from 79% of 9th graders to 60% of 12th graders. This may be because older students drive cars instead of riding bicycles
- Of the students who rode bicycles, 93% rarely or never wore a bicycle helmet; 92% of females and 94% of males rarely or never wore a helmet when riding on a bike. Eighty six percent of 9th, 96% of 10th, 97% of 11th, and 95% of 12th graders never or rarely wore a bicycle helmet.
- Forty three percent of students rode one or more times during the 30 days preceding the survey in a car or other vehicle driven by someone who had been drinking alcohol.
- A quarter (25%) of students had driven a car or other vehicle at least once after drinking alcohol during the 30 days preceding the survey. More males (29%) than females (21%) had driven a motor vehicle after drinking. A significant increase for drinking and driving was observed as grade level increased, from 7% for 9th graders to 38% for 12th graders.

[Source: Nebraska Surveillance Report: YRBS, published August 2004, NHHSS]
The YRBS is a self-administered, school-based survey for students in grades 9-12. The YRBS has been completed seven times in Nebraska during the spring semester: 1991, 1993, 1995, 1997, 1999, 2001, and 2003. YRBS is based on the self-reported health behaviors of a random sample of youth. This report presents results of data from 1991 to 2001.

Target Population:

Nebraska defines the Target Population as youth between 15 and 18 years of age in Nebraska.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as youth between 15 and 18 years of age, in a three county

area.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years
Gender: Female and Male
Geography: Rural
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To reduce the number of youth in grades 9-12 who drink and drive to less than 18 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work to create a community consensus that clearly states that underage alcohol use is illegal, unhealthy and unacceptable, by September 30, 2006.

Desired Impact Objective: To reduce the number of youth in grades 9-12 who ride in a vehicle with someone who has been drinking to less than 35 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work to create a community consensus that clearly states that underage alcohol use is illegal, unhealthy and unacceptable, by September 30, 2006.

Essential Service 6 - Enforce laws and regulations:

Desired Impact Objective: To reduce the number of youth in grades 9-12 who drink and drive to less than 18 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will assure compliance with laws forbidding sale of alcohol to minors, and will increase public awareness of the problem, by September 30, 2006.

Desired Impact Objective: To reduce the number of youth in grades 9-12 who ride in a vehicle with someone who has been drinking to less than 35 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will assure compliance with laws forbidding sale of alcohol to minors, and will increase public awareness of the problem, by September 30, 2006.

PROGRAM PROFILE

1. Program Title: INJURY AND VIOLENCE PREVENTION PROGRAM

2. Total Block Grant Funds to Program:

Current Year:

a. HO 15-6	$10,000
b. HO 15-13	$20,000
c. HO 15-20	$50,832
d. HO 15-27	$20,000
e. HO 15-35	$38,219
f. HO 26-1	$25,000
Total:	$164,051

Prior Year:

a. HO 15-6	$0
b. HO 15-13	$0
c. HO 15-20	$0
d. HO 15-27	$0
e. HO 15-35	$0
f. HO 26-1	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 15-6	$0
b. HO 15-13	$14,000
c. HO 15-20	$5,000
d. HO 15-27	$9,500
e. HO 15-35	$38,219
f. HO 26-1	$25,000
Total:	$91,719

4. Total FTE's for Program:

Number:

a. HO 15-6	0.10
b. HO 15-13	0.20
c. HO 15-20	0.50
d. HO 15-27	0.20
e. HO 15-35	0.00
f. HO 26-1	0.00
Total:	1.00

Description (Optional): The PHHS Block Grant supports activities addressing both unintentional and intentional injury.

Unintentional: PHHSBG funds support activities which focus on prevention of alcohol-related motor vehicle injury, improper child safety seat use, and falls.

Intentional: PHHSBG funds are used to support sexual offense prevention and victim services through a contract with the Nebraska Domestic Violence Sexual Assault Coalition and the 19 local rape crisis centers.

HEALTH OBJECTIVE PROFILE for HO 15-6 Child fatality review

5a. National Health Objective: 15-6 Child fatality review

Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.
An operational definition has not been specified.

6a. State Health Objective(s):

To reduce the infant mortality rate to no more than 4.5 per 1,000 live births, by September 30, 2010. *[Baseline: 6.8 per 1,000 live births]*

To reduce the neonatal death rate to no more than 2.9 per 1,000 live births, by September 30, 2010. *[Baseline; 4.5 per 1,000 live births]*

To reduce the postneonatal death rate to no more than 1.2 per 1,000 live births, by September 30, 2010. *[Baseline: 2.3 per 1,000 live births]*

To reduce the child death rate (aged one to four years) to no more than 17.4 per 100,000 population, by September 30, 2010. *[Baseline: 32.3 per 100,000 population]*

To reduce the child death rate (aged five to 9 years) to no more than 13.1 per 100,000 population, by September 30, 2010. *[Baseline: 18.8 per 100,000 population]*

To reduce the child death rate (aged 10 to 14 years) to no more than 18.0 per 100,000 population, by September 30, 2010. *[Baseline: 23.7 per 100,000]*

(These objectives are taken from "Nebraska 2010 Health Goals and Objectives", published May 2002.)

7a. Target and Disparate Population Numbers:

Target Number: 342,738
Disparate Number: 342,738

8a. HO Dollars/FTE's:

(1). Total Current Year: $10,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.10
(5). Amount of $'s to Local Entities for HO: $0

- Description (Optional): The state-level Injury Prevention and Control Program issues mini-grants to local coalitions and chapters, to support local child safety seat check-up events and educational workshops. ($12,065 total)
- The Injury Prevention and Control Program also issues small grants for ($14,000 total)

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-6 10-49% - Partial source of funding

10a. Block Grant Role:

HO 15-6 Supplemental Funding

Description (Optional): PHHSBG funds support one staff position within the NHHSS to address all unintentional injury issues.

The PHHS Block Grant supports a major part (45.5%) of the injury programming carried out by staff of the NHHSS Injury Prevention and Control Program.

NHHSS also receives about $120,000 from CDC for the comprehensive injury program.

11a. 10 Essential Services

Essential Service 1 - Monitor health status

HEALTH OBJECTIVE PROFILE for HO 15-13 Unintentional injury deaths

5b. National Health Objective: 15-13 Unintentional injury deaths

Reduce deaths caused by unintentional injuries.
35.0 deaths per 100,000 population were caused by unintentional injuries in 1998 (age adjusted to the year 2000 standard population).

6b. State Health Objective(s):

To reduce the death rate due to unintentional injuries to no more than 19.4 per 100,000 population, by September 30, 2010.

[Baseline: 38.8 deaths per 100,000 population, 1998]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002 by NHHSS)

7b. Target and Disparate Population Numbers:

Target Number: 575,971
Disparate Number: 342,738

8b. HO Dollars/FTE's:

(1). Total Current Year: $20,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.20
(5). Amount of $'s to Local Entities for HO: $14,000

- Description (Optional): The state-level Injury Prevention and Control Program issues mini-grants to local coalitions and chapters, to support local child safety seat check-up events and educational workshops. ($12,065 total)
- The Injury Prevention and Control Program also issues small grants for ($14,000 total)

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-13 10-49% - Partial source of funding

10b. Block Grant Role:

HO 15-13 Supplemental Funding

Description (Optional): PHHSBG funds support one staff position within the NHHSS to address all unintentional injury issues.

The PHHS Block Grant supports a major part (45.5%) of the injury programming carried out by staff of the NHHSS Injury Prevention and Control Program.

NHHSS also receives about $120,000 from CDC for the comprehensive injury program.

11b. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships

HEALTH OBJECTIVE PROFILE for HO 15-20 Child restraints

5c. National Health Objective: 15-20 Child restraints

Increase use of child restraints.
92 percent of children aged 4 and under were observed in safety seats or restraints in 1998.

6c. State Health Objective(s):

To increase the proportion of Nebraska children under the age of five years, who always use a child restraint when riding in a motor vehicle to no less than 100 percent, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002. The same document suggests that 80 percent might be a more reasonable objective for Nebraska, based on the observational survey results)

[Baseline: In 1997, the Nebraska BRFSS found 93 percent of adult respondents from households with the oldest child four years old or younger, reported that this child is always buckled into a car safety seat. Reported prevalence has remained steady since 1993. Note that this self-reported prevalence is significantly higher than the 66 percent recorded in 2000 observational survey.]

[Source: "Nebraska 2010 Health Goals and Objectives", published May 2002.]

7c. Target and Disparate Population Numbers:

Target Number: 117,048
Disparate Number: 11,560

8c. HO Dollars/FTE's:

(1). Total Current Year: $50,832
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $25,000
(4). Number of FTE's for HO: 0.50
(5). Amount of $'s to Local Entities for HO: $5,000

- Description (Optional): The state-level Injury Prevention and Control Program issues mini-grants to local coalitions and chapters, to support local child safety seat check-up events and educational workshops. ($12,065 total)
- The Injury Prevention and Control Program also issues small grants for ($14,000 total)

9c. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-20 10-49% - Partial source of funding

10c. Block Grant Role:

HO 15-20 Supplemental Funding

Description (Optional): PHHSBG funds support one staff position within the NHHSS to address all unintentional injury issues.

The PHHS Block Grant supports a major part (45.5%) of the injury programming carried out by staff of the NHHSS Injury Prevention and Control Program.

NHHSS also receives about $120,000 from CDC for the comprehensive injury program.

11c. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships

HEALTH OBJECTIVE PROFILE for HO 15-27 Falls

5d. National Health Objective: 15-27 Falls

Reduce deaths from falls.
4.7 deaths per 100,000 population were caused by falls in 1998 (age adjusted to the year 2000 standard population).

6d. State Health Objective(s):

To reduce deaths due to falls to less than 3.5 per 100,000 population, by September 30, 2010.

(Baseline 6.9 deaths per 100,000 population, 1998)
[Source: Nebraska 2010 Health Goals and Objectives, published by NHHSS, May 2002]

7d. Target and Disparate Population Numbers:

Target Number: 601,622
Disparate Number: 369,427

8d. HO Dollars/FTE's:

(1). Total Current Year: $20,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.20
(5). Amount of $'s to Local Entities for HO: $9,500

- Description (Optional): The state-level Injury Prevention and Control Program issues mini-grants to local coalitions and chapters, to support local child safety seat check-up events and educational workshops. ($12,065 total)
- The Injury Prevention and Control Program also issues small grants for ($14,000 total)

9d. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-27 10-49% - Partial source of funding

10d. Block Grant Role:

HO 15-27 Supplemental Funding

Description (Optional): PHHSBG funds support one staff position within the NHHSS to address all

unintentional injury issues.

The PHHS Block Grant supports a major part (45.5%) of the injury programming carried out by staff of the NHHSS Injury Prevention and Control Program.

NHHSS also receives about $120,000 from CDC for the comprehensive injury program.

11d. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships

HEALTH OBJECTIVE PROFILE for HO 15-35 Rape or attempted rape

5e. National Health Objective: 15-35 Rape or attempted rape

Reduce the annual rate of rape or attempted rape.
0.8 rapes or attempted rapes per 1,000 persons aged 12 years and older in 1998.

6e. State Health Objective(s):

To reduce the rate of rape and attempted rape among persons aged 12 years and older to no more than 0.2 per 1,000 population in Nebraska, by September 30, 2010.

[Baseline: 0.3 per 1,000 population in 1999 -- Based on the national survey, it is likely that the actual number of rapes and attempted rapes occuring in Nebraska is much higher]

(This objective was taken from the "Nebraska 2010 Health Goals and Objectives", published May 2002)

7e. Target and Disparate Population Numbers:

Target Number: 220,000
Disparate Number: 75,000

8e. HO Dollars/FTE's:

(1). Total Current Year: $38,219
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $38,219

Description (Optional): PHHSBG set-aside funds for Sexual Offense Prevention and Victim Services are subawarded to the Nebraska Domestic Violence Sexual Assault Coalition and the 19 local rape crisis centers across Nebraska.

Likewise, funds from the CDC categorical grant, now administered by the NHHSS Injury Program, called Rape Prevention and Education funds are subawarded to the Coalition and rape crisis centers.

9e. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-35 10-49% - Partial source of funding

10e. Block Grant Role:

HO 15-35 Supplemental Funding

Description (Optional): The PHHS Block Grant supports a major portion of the intentional injury prevention activities carried out by staff of the Injury Prevention and Control Program of the NHHSS.

It also supports a small portion of the work carried out by the the subawardee, the Nebraska Domestic Violence Sexual Assault Coalition.

11e. 10 Essential Services

Essential Service 2 - Diagnose and Investigate
Essential Service 3 - Inform and Educate

HEALTH OBJECTIVE PROFILE for HO 26-1 Alcohol and drug-related motor vehicle crashes

5f. National Health Objective: 26-1 Alcohol and drug-related motor vehicle crashes

Reduce deaths and injuries caused by alcohol and drug related motor vehicle crashes.
5.9 alcohol related motor vehicle crash deaths in 1998.

6f. State Health Objective(s):

To reduce deaths caused by alcohol-related motor vehicle crashes to no more than 4.0 per 100,000 population, by September 30, 2010.

[Baseline: 5.6 deaths per 100,000 population, 1998]
(Source: Nebraska 2010 Health Goals and Objectives, published May 2002 by NHHSS)

[Updated:

To reduce the rate of alcohol-related motor vehicle crashes to less than 10.3 per 100 million vehicle miles, by September 30, 2010.

[Baseline: 10.3 alcohol-related motor vehicle crashes per 100 million vehicle miles in 2004]
(Source: Highway Safety Program, Department of Motor Vehicles)

7f. Target and Disparate Population Numbers:

Target Number: 135,000
Disparate Number: 6,000

8f. HO Dollars/FTE's:

(1). Total Current Year: $25,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $13,000
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $25,000

Description (Optional): A district health department has been awarded funds to conduct "Project Extra Mile" in its three county coverage area.

9f. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 26-1 50-74% - Significant source of funding

10f. Block Grant Role:

HO 26-1 Supplemental Funding

Description (Optional): PHHSBG funds a prevention/enforcement program operated by a district health department in three counties.

11f. 10 Essential Services

Essential Service 4 - Mobilize partnerships
Essential Service 6 - Enforce laws and regulations

State Program Title: LABORATORY TESTING PROGRAM

State Program Strategy:

The HIV/STD Laboratory Testing Program provides low-cost or no cost laboratory testing for Nebraskans at high-risk for HIV and STDs (Gonorrhea, Chlamydia, and Syphilis).

The strategy selected for the PHHSBG-funded HIV/STD Program is provision of laboratory testing to clients whose behaviors put them at risk for infection and who may not otherwise have access to testing.

HIV testing is done through public clinics. Sexually Transmitted Disease testing is done in STD clinics, family planning facilities, correctional centers and other medical facilities seeing persons with high-risk behaviors. Laboratory screening is used to find asymptomatic infectious disease carriers, and leads to followup counseling and referral for treatment, thereby reducing the reservoir of infection.

The PHHS Block Grant supports a fraction of the cost of NHHSS-operated HIV and STD services, described below:

HIV:

The Nebraska Health and Human Services System, HIV Prevention Program's Vision and Mission is to lower HIV infection, illness and death rates for healthier Nebraskans and to create an environment of leadership, partnership and advocacy which fosters HIV prevention and the provision of services.

- The HIV/AIDS Prevention Program includes:
  - Health Education and Risk Reduction
  - Counseling Testing Referral / Partner Counseling and Referral
  - Subgrant Management and Special Projects
  - Public Information and Education
  - Assessment and Evaluation
  - Community Planning
- The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381) provides funding to States and other public or private nonprofit entities. It is to develop, organize, coordinate, and operate more effective and cost-effective systems for the delivery of essential health care and support services to medically underserved individuals and families affected by HIV.
- The Ryan White Title II Program includes:
  - AIDS Drug Assistance Program (ADAP)
  - Client Services
  - HIV Case Management
- The HIV Counseling, Testing and Referral Program provides funding to community based organizations and local health agencies for HIV antibody testing. The program administers federal funds and provides oversight of agency activities under state and federal guidelines. The program also ensures that free, anonymous and confidential testing services are offered while receiving written informed consent for client permission to preform the necessary laboratory tests to detect the presence

of HIV antibody in blood specimens.

- The Nebraska HIV CARE and Prevention Consortium (NHCPC) is a statewide community planning group that merges the prevention and care initiatives. AIDS Surveillance (collection of data, reporting, and tracking morbidity) and Sexually Transmitted Disease services (investigations, data collection, partner notification, and morbidity tracking) are administered under the Regulation and Licensure agency of the Nebraska Health and Human Services System. Close communication between all these programs ensures unified efforts, cross collaboration and best use of shared resource

STDs:

- **Confidentiality and surveillance**

STD reports are strictly confidential. In Nebraska, as in most states, syphilis; gonorrhea; HIV/AIDS; and chlamydia are reported to the appropriate health department. Laboratories and health care providers provide the health department with information for controlling and preventing sexually transmitted diseases. Prompt reporting and accurate identification is important:

- for clients that may need treatment,
- for identifying sex partners who may be infected, and
- for monitoring disease trends.

- **Intervention and prevention activities**

Health professionals interview infected people to identify, locate, and treat sex partners, to ensure proper treatment, and to provide information to help prevent reinfection.

- **Screening**

Testing people who have no signs or symptoms of illness is important in the control of STDs. The Nebraska Infertility Prevention Program works with cooperating family planning and health care facilities throughout the state testing 30,000 persons per year for chlamydia and gonorrhea.

- **Information and education**

The program makes available the latest guidelines regarding sexually transmitted diseases and their diagnosis and treatment to Nebraska's STD health care providers. Information and educational materials and posters are distributed to screening sites and community agencies.

National Health Objective: HO 13-1 HIV-AIDS

State Health Objective(s):

Increase the proportion of high-risk persons among those tested, by September 30, 2010.
[Baseline: Of the 5,924 tests performed in 2000, 3,672 or 62% were high risk clients.]

Decrease the proportion of HIV positive persons who progress to AIDS status, by September 30, 2010.
[Baseline: Of the 70 cases of HIV first diagnosed in 2000, 32 or 46% became AIDS.]

Assumptions:
(a) Targeting will improve the "yield" of testing, that is, increase the number awareness of their status among those at greatest risk for infection, rather than merely increase numbers of persons tested.
(b) Persons who know they are HIV positive will modify their behavior, which will lead to decreased transmission of the virus and earlier use of effective treatment.
(c) Earlier, more effective treatment will delay or prevent progression to AIDS.

Definition of High Risk for First Objective:
- *Men who have sex with men (MSM)*
- *Injecting drug use (IDU)*
- *Men who have sex with men who use injection drugs (MSM/IDU)*
- *Heterosexual persons who know one or more of their sex partners are IDU, MSM and HIV positive*
- *Sexual assault victims*
- *Sex workers*
- *Persons with an STD diagnosis*

The Nebraska Health and Human Services System published "Nebraska 2010 Health Goals and Objectives" in May 2002. The document addressed the extent of the problem in Nebraska, and described cumulative AIDS cases and new AIDS cases in Nebraska's population by exposure category, age, gender, race and ethnic origin as known in 2000. It also included information on deaths due to HIV/AIDS, rates of HIV infection, persons living with HIV/AIDS and the efficacy of condom use.

Nebraska 2010 also discussed each of the (Chapter 13) national Healthy People 2010 objectives. It also discussed the associated limitations and challenges:
- The unknown number of persons remaining unaware of their status (CDC estimated 25% of all persons with HIV infection have not sought testing and are unaware of their status),
- The time lapse of 8 to 10 years between initial infection with HIV and the progression to AIDS,
- The development of antiretroviral treatments, which are effective in preventing the progression from HIV to AIDS, and therefore increase survival times. The increased survival times increases the lifetime costs of health care associated with HIV infection. The existance of treatment regimens may lead to a false sense of security in the ability to control the disease and therefore lead to increased risk behavior and increased transmission.

In August, 2004, the Nebraska Health and Human Services System published the "Nebraska Comprehensive HIV Plan" for 2004 -2008, produced by the Nebraska HIV CARE and Prevention Consortium (NHCPC). The forward to that plan states:

"Programming for prevention and care of the Human Immunodeficiency Virus (HIV) has been an integral part of Nebraska Health and Human Services (HHS) activities for over a decade. Since January 1994, the department has implemented an ongoing, comprehensive planning process to improve the effectiveness of the HIV prevention and care programs of the department by strengthening the scientific basis and community relevance and by developing an HIV prevention and care plan that best represents the needs of populations infected with or at risk for HIV. The department is committed to a program that incorporates the views and perspectives of groups at risk for HIV infection, for whom the programs are intended, as well as providers of HIV prevention and care services. " (underlining added for emphasis)

Campaign to increase yield of testing:

The increase in high-risk individuals tested and HIV positive clients located from 2000 to 2001 and ensuing years was a direct result of program goals and objectives. The specific goals were to remove barriers to testing, get testing to high risk individuals in outreach settings, and decrease the time to get results to the client. In 2001, a new testing technology was introduced at several sites throughout the state and later expanded to all sites. As new testing technologies enter the HIV testing arena, access to high risk individuals becomes easier and result delivery time decreases, resulting in a higher percentage of individuals, particularly HIV positive, who receive their results.

State Health Problem:

HIV/AIDS:

HIV Disease Cases (not AIDS) Reported :

	Pre-2001	2001	2002	2003	2004	Total Number	%
Total HIV Cases by Year	383	75	46	46	48	598	100
Risk Status Not Identified	60	20	12	19	13	124	21
Risk Status Identified	323	55	34	27	35	374	79

Risk Status includes: Men who have sex with men (MSM), Injecting drug use (IDU), MSM/IDU, Adult treatment for hemophilia, Transfusion, Heterosexual contact, and Pediatric.

AIDS Cases: A total of 1,265 AIDS cases have been diagnosed among Nebraska residents from 1983 through 2003. The number of new AIDS cases has shown almost no variation during the last 6 years, after a rapid decrease from 1995 to 1998. Overall, AIDS cases increased from 1983 to 1992, when 99 cases were reported. The number of cases then remained stable through 1995, to then decline to 63 cases in 1998. From 1998, the number of AIDS cases increased to 73 in 2001 and then declined to 59 in 2003. The data for 2003 may not be complete due to delays in reporting.

AIDS Deaths: The number of deaths steadily increased from 1983 to 1994, when 86 deaths occurred. This increase was followed by a steep decrease from 86 in 1994 to 19 in 1999. Nineteen is the lowest number of deaths from AIDS reported in Nebraska since 1987. The number of deaths then increased again slightly, to 25 cases in 2000 and 38 in 2001, before declining again to 21 deaths in 2003.

CDC attributes the decrease in the number of AIDS cases and deaths since 1996 to the introduction of highly active antiretroviral therapy (HAART), which slows the progression of HIV infection to AIDS. In addition, improved methods have been introduced for preventing the occurrence of opportunistic infections (such as pneumocystis carinii pneumonia) and for better monitoring of HIV progression (such as by the determination of the individual's HIV viral load).

CDC states new AIDS cases increasingly represent persons who have failed HAART. These treatment failures occur for a variety of reasons, according to AIDSinfo, a website of the U.S. Department of Health and Human Services. They list such problems as not taking the medicines on a prescribed schedule; adverse side effects to the medications; and the development of HIV viral strains that are resistant to the currently available antiretroviral drugs. Other reasons cited by CDC for the occurrence of new AIDS cases is the limited access to or use of HIV testing, thus delaying the identification of HIV infected persons. In addition, limited access to HAART, medical care, and social services, by HIV infected persons, may be another

[Source: "HIV/AIDS Surveillance Report" December 31, 2004, published by the NHHSS]

The behaviors that place a person at risk for HIV include: anal sex involving either men or women without a condom; vaginal sex without a condom; oral sex without protection; sharing needles when injecting drugs; and home tattooing and piercing using non-sterile needles.

Commonly identified populations at risk for HIV include: men who have sex with men (MSM), high risk heterosexuals (HRH), injecting drug users (IDU), and men who have sex with men who are injecting drug users (MSM/IDU).

HIV is not transmitted through hugging, kissing, massage, shaking hands, or living in the same house with someone who has HIV.

[Source: "Nebraska Comprehensive HIV Plan 2004-2008" published by NHHSS in August 2004.]

Target Population:

Nebraska defines the Target Population as persons who have one or more of the factors listed below, and who are served through the public clinics.

(Number estimated from 2002 data on tests conducted)

Risk Factors

HIV is most commonly spread by sexual contact with an infected partner. It can also be spread through infected blood and shared needles or syringes contaminated with the virus. Untreated women with HIV can also pass the infection along to their babies during pregnancy, delivery, or through breast milk.

Persons are at greatest risk if they:

- Have unprotected sex with multiple partners (heterosexual, homosexual, or bisexual). Unprotected sex means having sex without using a new latex or polyurethane condom every time.
- Have unprotected sex with someone who is HIV-positive.

- Have another sexually transmitted disease, such as syphilis, genital herpes, chlamydia, gonorrhea, or bacterial vaginosis.
- Share needles during intravenous drug use.
- Are a person with hemophilia who received blood products between 1977 and April 1985 (the date when testing of blood for HIV began).
- Received a blood transfusion or blood products before 1985.
- Are a newborn or nursing infant of an HIV-positive mother.

Persons in any of these risk categories should be tested to determine their HIV status, so that they can modify their behaviors as needed to prevent transmission of the virus.

Testing of pregnant women to determine whether or not they are HIV-positive is also important in preventing transmission of the virus to their baby. Administering the drug zidovudine to the mother during pregnancy reduces the risk of transmission of HIV to the infant by as much as two-thirds.

[Source: "Nebraska 2010 Health Goals and Objectives", published May 2002]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population is the same as the Target Population.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: To maintain the system of testing for HIV, at no cost to the client, and reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors for infection, by September 30, 2009.

Annual Activity Objective: Subawardee will contract for laboratory testing on samples. Numbers of tests to be completed by September 30, 2006 are:

- 2,502 HIV EIA tests at $20 per test
- 50 HIV Western Block tests at $77 per test

National Health Objective: HO 25-1 Chlamydia

State Health Objective(s):

To reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescents and young adults, aged 15 to 24 years, to no more than three percent, by September 30, 2010.

(*This objective was taken from the "Nebraska 2010 Health Goals and Objectives", published May 2002)*

[Baseline: In Nebraska, prevalence of positive chlamydia tests was lower than the U.S. rate in each group. Among females aged 15 to 24 years attending family planning clinics, 3.3 percent tested positive for chlamydial infection. Seven percent of females attending STD clinics were found to be infected with chlamydia. Among males attending STD clinics, the proportion testing positive for chlamydia was higher, at 11.8 percent].

State Health Problem:

STDs:

◆ Despite recent progress toward controlling sexually transmitted diseases (STDs) in this country, STD rates in the United States are higher than those recorded in all other countries of the industrialized world. An estimated 15.3 million new infections occur nationwide each year—one-fourth of them in teenagers.

◆ For the leading viral sexually transmitted diseases (herpes, human papillomavirus, hepatitis B, and HIV), no cures are yet available so the number of persons who are infected increases year after year.

◆ Overall, STD incidence rates in Nebraska have declined over the past ten years. In 1999, there were 6,242 reported new cases of STDs (including chlamydia, gonorrhea, genital herpes and syphilis) in Nebraska.

◆ By age 24, at least one in three sexually active people will have contracted an STD. In Nebraska, two-thirds of all reported STD cases in 1995-1999 occurred among 15- to 24-year-olds.

◆ Non-Hispanic African Americans were far more likely than any other racial or ethnic group in Nebraska to have a reportable STD. In 1995-1999, the new case rate was 17.2 times the rate for non-Hispanic whites. Rates for Native Americans and Hispanic Americans in Nebraska were also much higher than the rate for non-Hispanic whites in the state.

Chlamydia

◆ Chlamydia accounted for more than one-half of all reported new STD cases in Nebraska. Rates of reported chlamydial infection over the last ten years experienced a low in 1996, but have risen since then.

◆ The proportion of individuals attending family planning or STD clinics who are diagnosed with chlamydia infection can be used as a rough approximation of prevalence of the disease in a population group. In Nebraska, 3.3 percent of females aged 15 to 24 attending family planning clinics tested positive for chlamydia. Among
people in this age range attending STD clinics, 7.0 percent of females and 11.8 percent of males were infected with this STD.

Chlamydia trachomatis infections are the most commonly reported notifiable disease in the United States and are among the most frequently occurring STDs. In women, chlamydial infections are usually asymptomatic and may result in pelvic inflammatory disease (PID). PID is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. As with other inflammatory STDs, chlamydial infection can facilitate the transmission of HIV infection. In addition, pregnant women infected with chlamydia can pass it on to their infants during delivery and potentially cause neonatal ophthalmia and pneumonia.

Incidence of Chlamydia

Overall, as more chlamydial infections have been diagnosed and treated, the number of actual new cases in the United States has declined from an estimated four million to about three million per year. Please note that this estimated number of new cases is much larger than the number of reported cases (about 700,000 in 2000), since many cases go undiagnosed.

The number of new reported chlamydia cases in the United States has risen in recent years, from 50.8 in 1987 to 257.5 cases per 100,000 persons in 2000. This increase is due primarily to increased use of screening and use of more sensitive testing methods instead of more new infections. Still, many women who are at risk for this infection are not being tested due to lack of awareness among health care providers of the need for screening and the limited resources available to support screening.

In Nebraska, 3,616 new cases of chlamydia were reported in 1999 (216.4 cases per 100,000 population). This incidence rate is lower than the U.S. rate. Rates of reported chlamydial infection over the last ten years experienced a low of 158.9 in 1996 but have risen since then.

Reported rates of new chlamydia infections are much higher among females than males in the United States, reflecting the larger number of women screened for the disease. In 1999, the rate for females in Nebraska (340.1) was nearly four times the rate for males (87.1).

Sexually active adolescents in the U.S. have high rates of chlamydial infection. In Nebraska, infection rates for 1995-1999 were by far the highest for teens aged 15 to 19 years (907.5) and young adults aged 20 to 24 years (968.4).

Prevalence of Chlamydia

The U.S. *Healthy People 2010* report uses the proportion of individuals attending family planning or STD clinics who are diagnosed with chlamydia infection as a rough approximation of prevalence of chlamydia in the population aged 15 to 24 years. Using this methodology, 5.0 percent of females nationwide attending family planning clinics and 12.2 percent of those attending STD clinics were found to have chlamydial infections. Among males attending STD clinics, 15.7 percent had chlamydia.

In Nebraska, prevalence of positive chlamydia tests was lower than the U.S. rate in each group. Among females aged 15 to 24 years attending family planning clinics, 3.3 percent tested positive for chlamydial infection. Seven percent of females attending STD clinics were found to be infected with chlamydia. Among males attending STD clinics, the proportion testing positive for chlamydia was higher
(11.8 percent).

[Source: "Nebraska 2010 Health Goals and Objectives", published by NHHSS in May 2002]

2000 - 2004 Chlamydia Statistics -

Nebraska Females and Males

	2000		2001		2002		2003		2004		2000-2004	
Statewide	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
	3799	222.0	3196	186.8	4595	268.5	4825	279.0	5241	301.3	21,656	250.7

Rates are per 100,000 population

[Source: NHHSS website, Sexually Transmitted Disease (STD) page, as updated 7/15/05]

Target Population:

Nebraska defines the Target Population as all women less than 25 years of age across the state.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska has defined the Disparate Population is the same as the Target Population.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: To maintain the system of testing for sexually transmitted diseases, at no cost to the client, and reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors for infection, by September 30, 2009.

Annual Activity Objective: Subawardee will contract with laboratory to provide testing on samples from 92 provider sites. Numbers of tests to be completed by September 30, 2006 are:

- 8,011 Chlamydia/Gonorrhea BD Amplified Tests, at $11.24 per test
- 3,956 Chlamydia/Gonorrhea BD Urine Tests at $16.45 per test

Testing for Chlamydia is expected to find about 1,797 persons infected.

National Health Objective: **HO 25-2 Gonorrhea**

State Health Objective(s):

To reduce the rate of new gonorrhea cases in Nebraska to no more than 17.0 cases per 100,000 people, by September 30, 2010.

[Baseline:Incidence of reported new gonorrhea cases in the state decreased by more than one-third between 1990 and 1998 . However, in 1999, the rate increased sharply to the current rate of 88.1]

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

State Health Problem:

STDs:

◆ Despite recent progress toward controlling sexually transmitted diseases (STDs) in this country, STD rates in the United States are higher than those recorded in all other countries of the industrialized world. An estimated 15.3 million new infections occur nationwide each year—one-fourth of them in teenagers.
◆ For the leading viral sexually transmitted diseases (herpes, human papillomavirus, hepatitis B, and HIV), no cures are yet available so the number of persons who are infected increases year after year.
◆ Overall, STD incidence rates in Nebraska have declined over the past ten years. In 1999, there were 6,242 reported new cases of STDs (including chlamydia, gonorrhea, genital herpes and syphilis) in Nebraska.
◆ By age 24, at least one in three sexually active people will have contracted an STD. In Nebraska, two-thirds of all reported STD cases in 1995-1999 occurred among 15- to 24-year-olds.
◆ Non-Hispanic African Americans were far more likely than any other racial or ethnic group in Nebraska to have a reportable STD. In 1995-1999, the new case rate was 17.2 times the rate for non-Hispanic whites. Rates for Native Americans and Hispanic Americans in Nebraska were also much higher than the rate for non-Hispanic whites in the state.

Gonorrhea

◆ Gonorrhea cases made up nearly one-fourth of all reported new STD cases in Nebraska in 1999. Nebraska's incidence rate was much lower than the national rate and had declined by more than one-third between 1990 and 1998 (although the 1999 rate represented a sharp increase).
◆ Incidence of gonorrhea was particularly high among non-Hispanic African Americans in Nebraska, with the 1995-1999 new case rate 58 times the corresponding rate for non-Hispanic whites.

Gonorrhea

Infections due to *Neisseria gonorrheae* are a major cause of PID in the United States. PID can lead to such serious outcomes as tubal infertility, ectopic pregnancy, and chronic pelvic pain. In addition, research studies provide strong evidence that gonococcal infections facilitate the transmission of HIV infection.

Antimicrobial resistance is an important consideration in the treatment of gonorrhea. Overall, 24.7 percent of isolates collected in 2000 by the Gonococcal Isolate Surveillance Project (GISP) were resistant to penicillin, tetracycline, or both.

Incidence of Gonorrhea

Following a decline of nearly 75 percent in the reported rate of gonorrhea from 1975 and 1997, in 1998 the gonorrhea rate in the United States increased and has remained steady through 2000. According to CDC, increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests, and improved reporting may account for part of this increase. However, true increases in disease in some populations and geographic areas also appear to have occurred.

In 2000, 358,995 cases of gonorrhea were reported in the United States, resulting in a rate of 131.6 new cases per 100,000 population. In 1999, 1,472 cases of gonorrhea were reported in Nebraska, with the state rate of 88.1 cases per 100,000 much lower than the national rate.

Incidence of reported new gonorrhea cases in the state decreased by more than one-third between 1990 and 1998 . However, in **1999**, the rate increased sharply to the **current rate of 88.1**.

Unlike chlamydia infection rates, gonorrhea reported infection rates were only about 19 percent higher for females in Nebraska (95.5 per 100,000) than they were for males (80.3) in 1999.

Rates of infection are disproportionately high among teenagers and young adults and among racial and ethnic minorities, both in the United States and in Nebraska. The highest age-specific reported rates of gonococcal infection occurred among 20- to 24-year-olds in Nebraska in 1995-1999 (360.1 new cases per 100,000
population), with the rate for 15- to 19-year-olds nearly as high (316.8).

Nationwide, the incidence rate for gonorrhea among non-Hispanic African Americans was 30 times the rate for non-Hispanic whites in the United States in 2000 . Gonorrhea rates for Native Americans and Hispanic Americans were also much higher than the rate for non-Hispanic white Americans.

In Nebraska as well, incidence of gonorrhea was by far the highest for non-Hispanic African Americans in 1995-1999 (994.2 cases per 100,000), with this rate 58 times the rate for non-Hispanic whites (17.1). Rates for Native Americans (131.7) and Hispanic Americans (67.6) in the state were also higher than the non-Hispanic white rate.

[Source: "Nebraska 2010 Health Goals and Objectives", published by NHHSS in May 2002]

2000 - 2004 Gonorrhea Statistics - Nebraska Females and Males

	2000		2001		2002		2003		2004		2000-2004	
Statewide	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**
	1537	89.8	1187	69.4	1423	83.2	1664	96.2	1144	65.8	6955	80.5

Rates are per 100,000 population

[Source: NHHSS website, Sexually Transmitted Disease (STD) page, as updated 7/15/05]

Target Population:

Nebraska defines the Target Population people between 15 and 25 years of age.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska has defined the Disparate Population is the same as the Target Population.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: To maintain the system of testing for sexually transmitted diseases, at no cost to the client, and reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors for infection, by September 30, 2009.

Annual Activity Objective: Subawardee will contract with laboratory to provide testing on samples from 92 provider sites. Numbers of tests to be completed by September 30, 2006 are:

- 8,011 Chlamydia/**Gonorrhea BD Amplified Tests**, at $11.24 per test
- 3,956 Chlamydia/**Gonorrhea BD Urine Tests** at $16.45 per test
- 2,076 **Gonorrhea Cultures** at $10.00 per test

Testing for Gonorrhea is expected to find about 548 persons infected.

National Health Objective: HO 25-3 Primary and Secondary Syphilis

State Health Objective(s):

To reduce the rate of new cases of primary and secondary syphilis in Nebraska to no more than 0.2 cases per 100,000 population, by September 30, 2010.

[Baseline: 0.4 cases per 100,000 in 1999.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

To eliminate sustained domestic transmission of primary and secondary syphilis. by September 30, 2010.

(Source: Sexually Transmitted Diseases Program, NHHSS)

State Health Problem:

STDs:

◆ Despite recent progress toward controlling sexually transmitted diseases (STDs) in this country, STD rates in the United States are higher than those recorded in all other countries of the industrialized world. An estimated 15.3 million new infections occur nationwide each year—one-fourth of them in teenagers.
◆ For the leading viral sexually transmitted diseases (herpes, human papillomavirus, hepatitis B, and HIV), no cures are yet available so the number of persons who are infected increases year after year.
◆ Overall, STD incidence rates in Nebraska have declined over the past ten years. In 1999, there were 6,242 reported new cases of STDs (including chlamydia, gonorrhea, genital herpes and syphilis) in Nebraska.
◆ By age 24, at least one in three sexually active people will have contracted an STD. In Nebraska, two-thirds of all reported STD cases in 1995-1999 occurred among 15- to 24-year-olds.
◆ Non-Hispanic African Americans were far more likely than any other racial or ethnic group in Nebraska to have a reportable STD. In 1995-1999, the new case rate was 17.2 times the rate for non-Hispanic whites. Rates for Native Americans and Hispanic Americans in Nebraska were also much higher than the rate for non-Hispanic whites in the state.

Syphilis

Syphilis is a genital ulcerative disease that is transmitted through direct contact with a syphilis lesion. It has been shown to facilitate the transmission of HIV. Untreated early syphilis during pregnancy results in perinatal death in up to 40 percent of cases and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in more than 70 percent of cases.

The primary stage of syphilis is usually marked by the appearance of a single sore (or chancre). The chancre lasts three to six weeks and heals on its own. If adequate treatment is not given, the infection

progresses to the secondary stage. The second stage begins when a rash appears, although the rash may not be noticeable. A person can easily pass the disease on to sex partners during the primary or secondary stages. The latent stage of syphilis begins when the secondary symptoms disappear. Without treatment, the infected person still has syphilis even though no symptoms are evident. The disease may then begin to damage internal organs and may eventually result in death.

Syphilis is easy to detect by means of an inexpensive blood test. Penicillin or other antibiotics are effective in treating and curing this disease.

Incidence of Syphilis

Reported incidence of primary and secondary (P&S) syphilis in the U.S. is at the lowest level since reporting began in 1941. In recent years, the majority of new cases of syphilis have been concentrated in a small number of geographic areas. These trends have led to the development of the National Plan to Eliminate Syphilis from the United States, announced by the Surgeon General in October 1999.

The rate of P&S syphilis in the United States has declined by 89 percent from 1990 through 2000. However, outbreaks of syphilis among men who have sex with men have been reported recently, possibly reflecting an increase in risk behavior associated with the availability of HAART therapy for HIV infection.

In 2000, there were 5,979 reported cases of P&S syphilis nationwide, or 2.2 cases per 100,000 population. **In Nebraska, rates have decreased since the early 1990's with only 6 cases reported in 1999 (0.4 per 100,000)**.

Syphilis incidence rates in the United States have generally declined in all racial and ethnic groups. Still, rates for African Americans, Native Americans, and Hispanic Americans continue to exceed those for non-Hispanic white Americans. In 2000, the incidence rate for primary and secondary syphilis reported for non-Hispanic African Americans (12.8 cases per 100,000) was 21 times greater than the rate for non-Hispanic white Americans (0.6). However, this difference was considerably less than that in 1996, when the rate of P&S syphilis among African Americans was 50 times greater than the rate for whites.

Among Native Americans, the U.S. rate was 2.6 new cases per 100,000 in 2000. Hispanic Americans recorded a somewhat lower rate (1.8 per 100,000), but this rate was still about triple the rate for non-Hispanic white Americans.

In Nebraska, rates of primary and secondary syphilis were low for the period 1995-1999. The five-year average rate for non-Hispanic African Americans in the state (6.1 new cases per 100,000) was much higher than the rate for non-Hispanic whites (0.1). However, the current rate for African Americans in Nebraska represents a decrease of about 90 percent from 1987. Hispanic Americans also experienced higher incidence of this disease (1.5) than non-Hispanic white persons.

[Source: "Nebraska 2010 Health Goals and Objectives", published by NHHSS in May 2002]

2000 - 2004 Early Syphilis Statistics - Nebraska Females and Males

	2000		2001		2002		2003		2004		2000-2004	
Statewide	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**
	3	0.2	6	0.4	4	0.2	11	0.5	5	0.3	29	0.3

Rates are per 100,000 population

[Source: NHHSS website, Sexually Transmitted Disease (STD) page, as updated 7/15/05]

Target Population:

Nebraska defines the Target Population as youth, young adults and minority women.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska has defined the Disparate Population is the same as the Target Population.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 12-19 years, 20-24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: To maintain the system of testing for sexually transmitted diseases, at no cost to the client, and reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors for infection, by September 30, 2009.

Annual Activity Objective: Subawardee will contract with laboratory to provide testing on samples from 92 provider sites. Numbers of tests to be completed by September 30, 2006 are:

- 4,100 Syphilis RPr Tests at $7.00 per test
- 40 Syphilis RPRQ Tests at $14.00 per test
- 36 Syphilis FTA Tests at $25.00 per test

t is anticipated 3 persons infected with syphilis.
Testing for Syphilis is expected to find about persons infected.

PROGRAM PROFILE

1. Program Title: LABORATORY TESTING PROGRAM

2. Total Block Grant Funds to Program:

Current Year:

a. HO 13-1	$53,894
b. HO 25-1	$153,771
c. HO 25-2	$12,550
d. HO 25-3	$40,600
Total:	$260,815

Prior Year:

a. HO 13-1	$0
b. HO 25-1	$0
c. HO 25-2	$0
d. HO 25-3	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 13-1	$0
b. HO 25-1	$0
c. HO 25-2	$0
d. HO 25-3	$0
Total:	$0

4. Total FTE's for Program:

Number:

a. HO 13-1	0.00
b. HO 25-1	0.00
c. HO 25-2	0.00
d. HO 25-3	0.00
Total:	0.00

Description (Optional): No personnel services are supported with this subaward. The PHHS Block Grant helps cover the cost of a portion of the **laboratory testing** done by the STD Program.

HEALTH OBJECTIVE PROFILE for HO 13-1 HIV-AIDS

5a. National Health Objective: 13-1 HIV-AIDS

Reduce AIDS among adolescents and adults.
19.5 cases of AIDS per 100,000 persons aged 13 years and older in 1998.

6a. State Health Objective(s):

Increase the proportion of high-risk persons among those tested, by September 30, 2010.
[Baseline: Of the 5,924 tests performed in 2000, 3,672 or 62% were high risk clients.]

Decrease the proportion of HIV positive persons who progress to AIDS status, by September 30, 2010.
[Baseline: Of the 70 cases of HIV first diagnosed in 2000, 32 or 46% became AIDS.]

Assumptions:
(a) Targeting will improve the "yield" of testing, that is, increase the number awareness of their status among those at greatest risk for infection, rather than merely increase numbers of persons tested.
(b) Persons who know they are HIV positive will modify their behavior, which will lead to decreased transmission of the virus and earlier use of effective treatment.
(c) Earlier, more effective treatment will delay or prevent progression to AIDS.

Definition of High Risk for First Objective:
- *Men who have sex with men (MSM)*
- *Injecting drug use (IDU)*
- *Men who have sex with men who use injection drugs (MSM/IDU)*
- *Heterosexual persons who know one or more of their sex partners are IDU, MSM and HIV positive*
- *Sexual assault victims*
- *Sex workers*
- *Persons with an STD diagnosis*

The Nebraska Health and Human Services System published "Nebraska 2010 Health Goals and Objectives" in May 2002. The document addressed the extent of the problem in Nebraska, and described cumulative AIDS cases and new AIDS cases in Nebraska's population by exposure category, age, gender, race and ethnic origin as known in 2000. It also included information on deaths due to HIV/AIDS, rates of HIV infection, persons living with HIV/AIDS and the efficacy of condom use.

Nebraska 2010 also discussed each of the (Chapter 13) national Healthy People 2010 objectives. It also discussed the associated limitations and challenges:
- The unknown number of persons remaining unaware of their status (CDC estimated 25% of all persons with HIV infection have not sought testing and are unaware of their status),
- The time lapse of 8 to 10 years between initial infection with HIV and the progression to AIDS,
- The development of antiretroviral treatments, which are effective in preventing the progression

from HIV to AIDS, and therefore increase survival times. The increased survival times increases the lifetime costs of health care associated with HIV infection. The existance of treatment regimens may lead to a false sense of security in the ability to control the disease and therefore lead to increased risk behavior and increased transmission.

In August, 2004, the Nebraska Health and Human Services System published the "Nebraska Comprehensive HIV Plan" for 2004 -2008, produced by the Nebraska HIV CARE and Prevention Consortium (NHCPC). The forward to that plan states:

"Programming for prevention and care of the Human Immunodeficiency Virus (HIV) has been an integral part of Nebraska Health and Human Services (HHS) activities for over a decade. Since January 1994, the department has implemented an ongoing, comprehensive planning process to improve the effectiveness of the HIV prevention and care programs of the department by strengthening the scientific basis and community relevance and by developing an HIV prevention and care plan that best represents the needs of populations infected with or at risk for HIV. The department is committed to a program that incorporates the views and perspectives of groups at risk for HIV infection, for whom the programs are intended, as well as providers of HIV prevention and care services. " (underlining added for emphasis)

Campaign to increase yield of testing:

The increase in high-risk individuals tested and HIV positive clients located from 2000 to 2001 and ensuing years was a direct result of program goals and objectives. The specific goals were to remove barriers to testing, get testing to high risk individuals in outreach settings, and decrease the time to get results to the client. In 2001, a new testing technology was introduced at several sites throughout the state and later expanded to all sites. As new testing technologies enter the HIV testing arena, access to high risk individuals becomes easier and result delivery time decreases, resulting in a higher percentage of individuals, particularly HIV positive, who receive their results.

7a. Target and Disparate Population Numbers:

Target Number: 5,800
Disparate Number: 5,800

8a. HO Dollars/FTE's:

(1). Total Current Year: $53,894
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $53,894
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): None of the funds go to local entities. It is used for **laboratory testing** carried out under contact to the University of Nebraska Medical Center's Public Health Laboratory and the Centers of Disease Detection lab in San Antonio, Texas to provide testing of samples.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 13-1 10-49% - Partial source of funding

10a. Block Grant Role:

HO 13-1 Supplemental Funding

Description (Optional): The PHHS Block Grant is used to partially support laboratory testing for HIV, as part of the Nebraska HIV Prevention Program. The program provides testing, confirmatory testing, reporting of findings, data reporting, tracking, partner/spousal notification.

In addition to the PHHS Block Grant funding, the Counseling and Testing receives a total of $337,200 in other funding to support staff positions and testing. The PHHS Block Grant funds represent about 13.6% of the total Counseling and Testing Budget.

The Nebraska HIV/AIDS Program budget includes a CDC Prevention Grant amounting to $1,392,367. The PHHS Block Grant represents about 3.8% of the total prevention budget.

11a. 10 Essential Services

Essential Service 2 - Diagnose and Investigate

HEALTH OBJECTIVE PROFILE for HO 25-1 Chlamydia

5b. National Health Objective: 25-1 Chlamydia

Reduce the proportion of adolescents and young adults with Chlamydia trachomatic infections. 5.0 percent positive tests among women aged 15 to 24 years attending family planning clinics in 1997. 12.2 percent positive tests among women aged 15 to 24 years attending STD clinics in 1997. 15.7 percent positive tests among males aged 15 to 24 years attending STD clinics in 1997.

6b. State Health Objective(s):

To reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescents and young adults, aged 15 to 24 years, to no more than three percent, by September 30, 2010.

(*This objective was taken from the "Nebraska 2010 Health Goals and Objectives", published May 2002)*

[Baseline: In Nebraska, prevalence of positive chlamydia tests was lower than the U.S. rate in each group. Among females aged 15 to 24 years attending family planning clinics, 3.3 percent tested positive for chlamydial infection. Seven percent of females attending STD clinics were found to be infected with chlamydia. Among males attending STD clinics, the proportion testing positive for chlamydia was higher, at 11.8 percent].

7b. Target and Disparate Population Numbers:

Target Number: 124,704
Disparate Number: 124,704

8b. HO Dollars/FTE's:

(1). Total Current Year: $153,771
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $153,771
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): None of the funds go to local entities. They are used for **laboratory testing** carried out under contact to the University of Nebraska Medical Center's Public Health Laboratory to provide testing of samples.

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 25-1 50-74% - Significant source of funding

10b. Block Grant Role:

HO 25-1 Supplemental Funding

Description (Optional): PHHS Block Grant funds are used to support **laboratory testing for STDs,** carried out under contact to the University of Nebraska Medical Center, enabling the Communicable Disease Program to find and treat infected people, resulted in prevention of complications, medical and hospital costs.

The NHHSS STD Program receives funds from CDC for Chlamydia and Gonorrhea screening in the amount of $114,668. The STD Program also receive a $50,000 grant for testing pregnant women. State funds received support personnel costs, not testing, and amount to $123,712. The PHHS Block Grant represents 41.8% of all funds received, but more than 55% of funding available for testing.

11b. 10 Essential Services

Essential Service 2 - Diagnose and Investigate

HEALTH OBJECTIVE PROFILE for HO 25-2 Gonorrhea

5c. National Health Objective: 25-2 Gonorrhea

Reduce gonorrhea.
123 new cases of gonorrhea per 100,000 population in 1997.

6c. State Health Objective(s):

To reduce the rate of new gonorrhea cases in Nebraska to no more than 17.0 cases per 100,000 people, by September 30, 2010.

[Baseline:Incidence of reported new gonorrhea cases in the state decreased by more than one-third between 1990 and 1998 . However, in 1999, the rate increased sharply to the current rate of 88.1]

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

7c. Target and Disparate Population Numbers:

Target Number: 255,240
Disparate Number: 255,240

8c. HO Dollars/FTE's:

(1). Total Current Year: $12,550
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $12,550
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): None of the funds go to local entities. They are used for **laboratory testing** carried out under contact to the University of Nebraska Medical Center's Public Health Laboratory to provide testing of samples.

9c. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 25-2 10-49% - Partial source of funding

10c. Block Grant Role:

HO 25-2 Supplemental Funding

Description (Optional): PHHS Block Grant funds are used to support **laboratory testing for STDs,** carried out under contact to the University of Nebraska Medical Center, enabling the Communicable Disease Program to find and treat infected people, resulted in prevention of complications, medical and hospital costs.

The NHHSS STD Program receives funds from CDC for Chlamydia and Gonorrhea screening in the amount of $114,668. The STD Program also receive a $50,000 grant for testing pregnant women. State funds received support personnel costs, not testing, and amount to $123,712. The PHHS Block Grant represents 41.8% of all funds received, but more than 55% of funding available for testing.

11c. 10 Essential Services

Essential Service 2 - Diagnose and Investigate

HEALTH OBJECTIVE PROFILE for HO 25-3 Primary and Secondary Syphilis

5d. National Health Objective: 25-3 Primary and Secondary Syphilis

Eliminate sustained domestic transmission of primary and secondary syphilis.
3.2 new cases per 100,000 population in 1997.

6d. State Health Objective(s):

To reduce the rate of new cases of primary and secondary syphilis in Nebraska to no more than 0.2 cases per 100,000 population, by September 30, 2010.

[Baseline: 0.4 cases per 100,000 in 1999.]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

To eliminate sustained domestic transmission of primary and secondary syphilis. by September 30, 2010.

(Source: Sexually Transmitted Diseases Program, NHHSS)

7d. Target and Disparate Population Numbers:

Target Number: 500,000
Disparate Number: 500,000

8d. HO Dollars/FTE's:

(1). Total Current Year: $40,600
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $40,600
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): None of the funds go to local entities. They are used for **laboratory testing** carried out under contact to the University of Nebraska Medical Center's Public Health Laboratory to provide testing of samples.

9d. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 25-3 10-49% - Partial source of funding

10d. Block Grant Role:

HO 25-3 Supplemental Funding

Description (Optional): PHHS Block Grant funds are used to support **laboratory testing for STDs,** carried out under contact to the University of Nebraska Medical Center, enabling the Communicable Disease Program to find and treat infected people, resulted in prevention of complications, medical and hospital costs.

The NHHSS STD Program receives funds from CDC for Chlamydia and Gonorrhea screening in the amount of $114,668. The STD Program also receive a $50,000 grant for testing pregnant women. State funds received support personnel costs, not testing, and amount to $123,712. The PHHS Block Grant represents 41.8% of all funds received, but more than 55% of funding available for testing.

11d. 10 Essential Services

Essential Service 2 - Diagnose and Investigate

State Program Title: PHYSICAL ACTIVITY AND NUTRITION PROGRAM

State Program Strategy:

❤ The aim of the Physical Activity and Nutrition (PAN) Program is to build infrastructure through policy and environmental strategies for physical activity and nutrition at multiple levels -- community, school, worksite and faith organization.

The PAN Program has two major components: the Nutrition Education Component and the Physical Activity Component.

⏩ **Specific strategies selected for the PHHSBG-funded PAN Program include: use of proven educational techniques for individual behavior change, facilitation of environmental and policy change, and building capacity in communities.**

Strategies and activities of both PAN Program components are designed to decrease overweight and obesity, which are linked to subsequent cardiovascular disease, cancer and diabetes.

✐ Nutrition Education Component:

The purpose of the Nutrition Education Component is to increase knowledge, and enhance opportunities to eat wisely and maintain a healthy weight.

The Nebraska Health and Human Service System (NHHSS) has multiple programs and functions which address nutrition-related topics. Activities carried out include: issuing public health messages through the media about healthful eating and prevention of obesity, breast feeding and food sanitation; making educational presentations; providing financial assistance or commodity food to target populations in acquiring healthy food; and issuing nutrition rules and regulations for agencies serving people with certain health conditions.

Other NHHSS nutrition programs:

▸ WIC is the Special Supplemental Nutrition Program for Women, Infants and Children. Nebraska WIC participants must: a) live in Nebraska, b) be a pregnant woman, postpartum or breastfeeding woman, infant or child under five years of age, c) have nutritional risks, such as: inadequate weight gain, overweight, underweight, inadequate diet, anemia, and d) have a household income that is up to 185% of poverty. The WIC Program is available at approximately 120 clinic sites located throughout Nebraska. Participants shop for WIC approved foods at over 400 authorized stores across Nebraska. The program has four basic goals to: 1) provide education on nutrition and health, 2) Encourage breastfeeding for the first 12 months of an infant's life, 3) Provide supplemental foods at no cost to participants, 4) Provide regular health care through referrals. As of mid-FY2005, the program was serving an average of 41,000 participants each month.

▸ CSFP, the Commodity Supplemental Food Program, provides foods purchased and distributed through the USDA to: a) infants up to 12 months of age, b) children from one year of age up to the sixth birthday, c) women who are pregnant, breastfeeding and/or who have had a baby within the past year, d) seniors age 60 and greater. The program provides formula, rice ceral and juice to infants; and milk, eggs, fruits and vegetables, cereal, rice, potatoes, macaroni, canned meat, peanut butter, and

cheese to children, women and seniors. Fathers, guardians, and foster parents are encouraged to apply for benefits for their children. As of mid-fiscal year 2005, the program was serving an average of 14,105 persons per month.

- Nutrition Services for Older Adults: some 250 sites exist in Nebraska and provide excellent opportunities for socialization, relaxation and participation in programs and activities. Site services, which may include congregate and home-delivered meals, nutrition and health promotion education, transportation, counseling, information and assistance, legal assistance, and health screening, enhance the choices of older people in the community. Congregate meal sites are located throughout the state in senior centers, schools, churches, community centers, and other public and private facilities. When older people cannot leave their homes and cannot personally prepare nutritious meals, home delivered meals may be provided.

Physical Activity Component**:**

The purpose of the Physical Activity Component is to increase the activity level of Nebraskans to meet the recommendations of the U.S. Surgeon General which are, "every American adult should accumulate 30 minutes of physical activity over the course of the day, most days of the week".

The CDC issued "Increasing Physical Activity: A Report on Recommendations of the Task Force on Community Prevention Services" on Oct 26, 2001. A portion of the Summary reads:

"The Task Force either strongly recommends or recommends six interventions: two informational approaches (i.e., community-wide campaigns and point-of-decision prompts to encourage use of stairs); three behavioral and social approaches (i.e., school-based physical education, social support interventions in community settings [e.g., setting up a buddy system of contracting with another person to complete specified levels of physical activity], and individually adapted health behavior change programs); and one intervention to increase physical activity by using environmental and policy approaches (i.e., creation of or enhanced access to places for physical activity combined with informational outreach activities)."

The Physical Activity Component has incorporated some of these interventions in working with partners at the community level.

National Health Objective: **HO 19-2 Obesity in adults**

State Health Objective(s):

To reduce the proportion of Nebraska adults, aged 18 and older, who report heights and weights that place them in the "obese" category (Body Mass Index BMI of 30 or more) to no more than 15 percent, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

State Health Problem:

Prevalence and trend:

◆ In Nebraska, 59 percent of adults aged 18 years or older responding to the self-reported Behavioral Risk Factor Surveillance Survey (BRFSS) were categorized as overweight or obese, based on BMI definitions.

◆ During 1999-2000, 38 percent of adults in Nebraska were classified as overweight but not obese, based on BRFSS data. This proportion is 12 percent higher than that reported in 1989 (33 percent). The greatest share of the increase in overweight and obesity has occurred in the obese category.

◆ Prevalence of obesity has risen substantially in Nebraska and the nation. Based on BRFSS data, from 1989 through 1992, the proportion of adults who were obese was stable at 12 to 13 percent. Since then prevalence has risen by about 75 percent, so that 21 percent of Nebraska adults were classified as obese in 1999 and 2000.

◆ Men were somewhat more likely than women to report weight and height that placed them in the obese category (24 percent vs. 18 percent for women) in 1999-2000. The proportion of respondents who were overweight or obese was also higher among men (68 percent) than women (48 percent), based on self-reported heights and weights.

◆ In general, prevalence of obesity increased with increasing age of respondent through age 64. The proportion of respondents who were obese ranged from a low of 12 percent for young adults aged 18 to 24 to a high of 27 percent for respondents aged 55 to 64.

◆ Rural residents (22 percent) were slightly more likely than persons living in urban areas (20 percent) to be obese.

◆ Respondents with less than a college degree were, in general, more likely to be categorized as obese than college graduates. In 1999-2000, 22 to 23 percent of these adults were obese, compared to 18 percent of college graduates.

◆ Persons with annual household incomes below $50,000 per year reported a higher prevalence of obesity (22 to 25 percent) than did those earning $50,000 or more (18 percent).

Consequences:

◆ Overweight and obesity substantially raise the risk of illness from: heart disease and stroke; high blood pressure; elevated blood cholesterol levels; type 2 diabetes; endometrial, breast, prostate, and colon cancers; gallbladder disease; arthritis; sleep disturbances; and problems breathing. Obese

persons (both children and adults) may also suffer from social stigmatization, and lowered self-esteem.

Definitions:
The Body Mass Index (BMI) is used as a proxy measure for overweight and obesity in adults until a better method of determining actual body fat is developed. It is calculated by dividing weight in kilograms by the square of height in meters.

Overweight (including obesity) is defined as a BMI of 25.0 or greater. A BMI of 30.0 or greater signifies obesity, while "overweight but not obese" is defined as a BMI of 25.0 to 29.9. Although these standards have been defined, health risks due to overweight and obesity occur along a continuum and do not conform to specific cut-points.

Development of Obesity:
Reduced to the most basic terms, much of the current increase in obesity can be attributed to the simple fact that people (adults and children alike) are consuming more calories than they are using. Additionally, only 21% of respondents to the Nebraska 2000 BRFSS reported consuming fruits and vegetables the recommended five or more times daily.

During 1999-2000, nearly three in every ten adults (29 percent) responding to the BRFSS stated they had not participated in any leisure-time physical activities in the past month. Of the remainder, just 12% participated in "regular and vigorous" leisure time physical activity in the past month.

Target Population:

Nebraska defines Target Population as adults who are overweight or obese.

(2000 Census: 1,261,021 adult population, 18 years and older)
(58% obese or overweight)

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population as the number of obese adults.

(2000 Census: 1,261,021 adults population, 18 years or older)
(About 21.2% of adults were reported to be obese in 2000)

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male

Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain at least 20 active partnerships with organizations supporting physical activity, nutrition and/or obesity prevention, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain a communication/sharing plan for both NHHSS and external partners, by September 30, 2006.

Annual Activity Objective: Subawardee will work with at least 3 statewide Organizations, including NAHPHRD, Healthy Kids Teams, Governor's Council on Health Promotion and Physical Fitness, and the Advisory Committee for the Nebraska Physical Activity and Nutrition State Plan.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the

state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

National Health Objective: HO 19-3 Overweight or obesity in children and adolescents

State Health Objective(s):

To reduce the proportion of Nebraska children and youth who are overweight or obese, to no more than 3% among those 12 to 19 years of age, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May, 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

State Health Problem:

Prevalence and consequences:

◆ Obesity among both youth and adults in America is increasing at epidemic levels. Between 1976-1980 and 1999-2000, the percentage of overweight U.S. children (ages 6-11) more than doubled (increasing 135%) while the percentage of overweight adolescents (ages 12-19) more than tripled (increasing 210%). Overweight and obese individuals are at increased risk for both physical and emotional disorders. Furthermore, many of the health conditions resulting from overweight and obesity that were previously not evident until adulthood are beginning to appear in youth.

◆ In Nebraska, 1 in every 6 students (16.2%) in grades K-12 is overweight while an additional 1 in every 6 (17.1%) is at risk for overweight. This indicates that 1 in every 3 (33.3%), or approximately 106 thousand Nebraska students, is either at risk for overweight or overweight. Students at greatest risk for overweight include males, students in grades 4-6, Hispanic and Native American students, and students in the south central Nebraska region.

◆ The physical and emotional impacts of overweight and obesity are extraordinary. Obese individuals are 50 to 100 percent more likely to die prematurely from any cause than individuals at a healthy body weight. In addition, overweight and obesity substantially increase the risk for (among other diseases) coronary heart disease, type 2 diabetes, some forms of cancer, and certain musculoskeletal disorders such as osteoarthritis. Overweight and obese individuals also may suffer from social stigmatization, discrimination, and poor body image.

Definition of overweight among children and youth:

BMI Categories	*Age and Gender Specific BMI Cut-off Values*
Underweight	<5th Percentile
Healthy Weight	>5th Percentile but <85th Percentile
At Risk for Overweight	>85th Percentile but <95th Percentile
Overweight	>95th Percentile

*BMI values are categorized based on gender and age specific values from the 2000 CDC Growth Charts. Source: BMI for Children and Teens. (2003). Division of Nutrition and Physical Activity, CDC. Available at <http://www.cdc.gov/nccdphp/dnpa/bmi/bmi-forage. htm>

Development of Obesity:

The high prevalence of overweight among Nebraska youth is resulting from an imbalance of physical activity and healthy eating. According to the American Obesity Association, today's youth are considered the most inactive generation in history, caused in part by reductions in school physical education programs and unavailable or unsafe community recreational facilities.

Data from the 2003 Nebraska Youth Risk Behavior Survey (YRBS) indicate that many Nebraska high school students (in grades 9-12) are not engaging in sufficient levels of physical activity, are engaging in excessive levels of television viewing, video game system use, and computer use (excluding homework), electronic sedentary behavior (ESB), and are eating unhealthy diets.

[Source: *Overweight Among Nebraska Youth: 2002/2003 Academic School Year,* published by the Nebraska Cardiovascular Health Program, Office of Disease Prevention and Health Promotion, June 2004.]

Given these devastating trends in overweight among youth nationally and the lack of quality data available for youth in Nebraska, the Nebraska Health and Human Services System developed and implemented a project to collect heights and weights from a representative sample of Nebraska students in grades K-12.

Data were collected on 40,154 Nebraska students in grades K-12 from 234 Nebraska schools. The data presented in this report represent students in grades K-12 from both public and non-public schools in Nebraska. Furthermore, these data were obtained through actual height and weight measurements taken within Nebraska schools, providing highly reliable and valid data.

Target Population:

Nebraska defines Target Population as students who are overweight (16.2%) or at risk for overweight (17.1%).

[Source: Overweight Among Nebraska Youth: 2002/2003 Academic School Year, published by the Nebraska Cardiovascular Health Program, Office of Disease Prevention and Health Promotion, June 2004.]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population as the number of students who are obese (16.2%).

[Source: Overweight Among Nebraska Youth: 2002/2003 Academic School Year, published by the Nebraska Cardiovascular Health Program, Office of Disease Prevention and Health Promotion, June 2004.]

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6-week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

Desired Impact Objective: Increase to 80% (from 33 to 41) the proportion of public elementary schools in the nine county coverage area of one district health department that provide school-site

nutrition education classes fro fifth grade students, which are based on research-proven curricula and taught by trained individuals, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will implement the Child Nutrition Education Program curriculum using trained UNL Cooperative Extension Educators in 12 public elementary schools, reaching a minimum of 128 fifth grade students, and establish a family involvement component involving at least 75 families of fifth grade students adopting healthier eating habits and increased physical activity, by September 30, 2006.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain at least 20 active partnerships with organizations supporting physical activity, nutrition and/or obesity prevention, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will maintain a communication/sharing plan for both NHHSS and external partners, by September 30, 2006.

> **Annual Activity Objective:** Subawardee will work with at least 3 statewide Organizations, including NAHPHRD, Healthy Kids Teams, Governor's Council on Health Promotion and Physical Fitness, and the Advisory Committee for the Nebraska Physical Activity and Nutrition State Plan.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.
>
> - Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6-week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

Desired Impact Objective: To increase from 0 to 20 the number of public schools in nine counties within the district health department jurisdication that adopt a school-based nutrition program policy based on Federal dietary recommendations and guidelines, by September 30, 2006.

National Health Objective: **HO 22-1 Physical Activity in Adults**

State Health Objective(s):

To increase the percentage of Nebraska adults, aged 18 and older, who engaged in regular and sustained physical activity in the preceding month to at least 30 percent, by September 30, 2010.

[Baseline: 20 percent in 1999]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

State Health Problem:

Lack of Adequate Physical Activity Facts:

- Regular physical activity provides a range of benefits for those who participate in it. Regular exercise is associated with lower death rates for adults of all ages, even when only moderate levels of activity are performed.
- In 1999, 27 percent of adults aged 18 and older who responded to the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) reported engaging in no leisure-time physical activities in the past month. Self-reported prevalence of physical inactivity in the state was up from a low of 23 percent in 1996.
- One-fifth of adult BRFSS respondents in Nebraska reported that they participated in “regular and sustained” physical activity (the level recommended by the U.S. Surgeon General to improve health) in their leisure hours during the previous month. This proportion is only slightly higher than the 1992 rate of 18 percent participation.
- Only 10 percent of adults in the state said that they participated in leisure-time activities that would be categorized as “regular and vigorous” (for example, running or swimming laps). This rate is the lowest recorded in the state since the question was first asked in the 1991-1992 BRFSS.
- In general, women have lower rates of physical activity than men. People with lower incomes and less education, African Americans and Hispanic Americans (compared to whites), people with disabilities, and people over 75 years of age are all groups that tend to have lower rates of physical activity.
- In Nebraska, one-fifth of BRFSS respondents (20 percent in 1999) engaged in regular and sustained exercise in the previous month.

Target Population:

Nebraska defines Target Population as the number adults who say their leisure time physical activity is less than "regular and sustained".

(2000 Census: 1,261,021 adult population, 18 years of age and older)
(1999 BRFSS: Only 20 percent of adults said they participated in leisure time activities that would be categorized as "regular and sustained ")

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population as adults who say they engage in no leisure time physical activity.

(2000 Census: 1,261,021 adult population, 18 years of age and older)
(1999 BRFSS: 27% of adults surveyed reported no leisure time physical activity)

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical

Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To maintain or expand community-based physical activity programs in at least 10 counties, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain a walking program in two communities, by September 30, 2006.

Annual Activity Objective: Subawardee will provide minigrant financial incentives to county cardiovascular health teams to support continued physical activity or walking activities, reaching at least 200 people in a 16-week program and at least 500 people who will increase their physical activity level , by September 30, 2006.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain at least 20 active partnerships with organizations supporting physical activity, nutrition and/or obesity prevention, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain a communication/sharing plan for both NHHSS and external partners, by September 30, 2006.

Annual Activity Objective: Subawardee will work with at least 3 statewide Organizations, including NAHPHRD, Healthy Kids Teams, Governor's Council on Health Promotion and Physical Fitness, and the Advisory Committee for the Nebraska Physical Activity and Nutrition State Plan.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational

services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6-week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

National Health Objective: **HO 22-6 Physical Activity in Children and Adolescents**

State Health Objective(s):

To increase the proportion of adolescents in grades 9-12 in Nebraska who engage in moderate physical activity for at least 30 minutes on 5 or more days of the previous 7 days to at least 35 percent, by September 30, 2010.

(Baseline: 28 percent in 1999)
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

State Health Problem:

Lack of Adequate Physical Activity Facts:

◆ Children and adolescents also benefit from exercise. The improvements in cardiorespiratory fitness, blood pressure control, and weight management to be gained from participation in moderate and vigorous physical activity are especially important in light of the increasing prevalence of obesity among children and adolescents.

◆ Data from the 2003 Nebraska Youth Risk Behavior Survey (YRBS) indicate that many Nebraska high school students (in grades 9-12) are not engaging in sufficient levels of physical activity, are engaging in excessive levels of television viewing, video game system use, and computer use (excluding homework), electronic sedentary behavior (ESB)), and are eating unhealthy diets.

Physical Inactivity

• More than 3 in every 4 students (76.7%) do not engage in sufficient levels of both moderate physical activity (participation in activities that did not make them sweat or breath hard for at least 30 minutes on five or more of the seven days preceding the survey) and vigorous physical activity (participation in activities that made them sweat and breath hard for at least 20 minutes on three or more of the seven days preceding the survey). Participation in sufficient vigorous physical activity declined 7 percent between 1991 (69.6%) and 2003 (64.7%) ($p < .001$).

Electronic Sedentary Behaviors

• During an average school day, Nebraska high school students spend more than 3½ hours (3.65 hours) engaging in ESB, including television viewing, video game system use, and computer use [excluding homework].

• Specifically, during an average school day, students spend approximately 1 hour and 45 minutes (1.78 hours) watching TV, 1 hour and 15 minutes (1.25 hours) using the computer (excluding homework) and approximately 30 minutes (0.55 hours) playing video games on a video game system.

• Three in every four students (75.6%) spend 2 or more hours engaging in ESB during an average school day while more than 1 in every 4 (27.3%) spends 5 or more hours daily.

[Source: *Overweight Among Nebraska Youth: 2002/2003 Academic School Year*, published by the Nebraska Cardiovascular Health Program, Office of Disease Prevention and Health Promotion, June 2004.]

Consequences:
The health effects of physical activity are not limited to adults. Children and adolescents benefit from improvements in cardiorespiratory fitness, blood pressure control, and weight management associated with moderate and vigorous physical activity. In addition, a physically active lifestyle that is adopted early in life may be more likely to continue into adulthood. Research has shown that even among children as young as three or four years of age, those who were less active tended to remain less active than most of their peers after age three.

Physical activity levels generally decline during adolescence, with a sharper decrease occurring in girls than in boys. Participation in team sports and vigorous exercise drops for both boys and girls, according to the Youth Risk Behavior Survey (YRBS).

In recent years, the proportion of children and adolescents who are obese has been increasing. Along with the rise in prevalence of obesity, there has been an increase in cardiovascular disease risk factors, including type 2 diabetes among children. Health researchers attribute this trend, in part, to children spending more time watching television or using the computer. Studies show that American children are watching an average of 1,000 hours of television each year (about three hours every day), at the expense of time spent being physically active.

[Source: "Nebraska 2010 Health Goals and Objectives", published May 2002]

Target Population:

Nebraska defines Target Population as youth who do not engage in moderate physical activity, at least 30 minutes, 5 days per week.

(Census 2000: 263,843 youth, aged 10 to 19)
(1999 YRBS: 28 percent of students surveyed stated they had engaged in moderate physical activity for at least 30 minutes on at least five of the seven days prior to the survey)

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines Disparate Population as the same as the Target Audience.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 4-11 years, 12-19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6-week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain at least 20 active partnerships with organizations supporting physical activity, nutrition and/or obesity prevention, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain a communication/sharing plan for both NHHSS and external partners, by September 30, 2006.

Annual Activity Objective: Subawardee will work with at least 3 statewide Organizations, including NAHPHRD, Healthy Kids Teams, Governor's Council on Health Promotion and Physical Fitness, and the Advisory Committee for the Nebraska Physical Activity and Nutrition State Plan.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To provide at least 50 professional education services addressing nutrition and obesity prevention and related topics, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical and financial support for physical activity, nutrition and obesity related projects, by September 30, 2006.

- Activities will include providing training and sponsoring conferences for local health departments and Native American Tribes and worksite wellness representatives.

. **Annual Activity Objective:** Subawardee will offer at least 14 informational services to Nebraska residents, by September 30, 2006.

- Activities will include providing materials in English and Spanish, newsletters, webpage promotion, updated data, pedometer curriculum, Youth and Adult Physical Activity and Nutrition Lifestyle Modification Prescription Forms, and culturally appropriate nutrition materials for Nebraska's four Native American Tribes.

Desired Impact Objective: Implement 45 policy and environmental interventions for physical activity and nutrition, by September 30, 2009.

Annual Activity Objective: Subawardee will work with 3 local public health departments to implement a walkable community environmental change project, by September 30, 2006.

Annual Activity Objective: Subawardee will work with Creighton University School of Nursing students to pilot a project integrating the "Youth Physical Activity and Nutrition Lifestyle Modification Rx Form" and the All Recreate Fridays (ARF) project in 19 Catholic Schools in Omaha, Nebraska, by September 30, 2006.

Annual Activity Objective: Subawardee will continue to monitor and provide technical assistance to 11 schools awarded "Project Drink Milk" fund in

FY2003 and FY2004.

Desired Impact Objective: To continue "All Recreate Fridays (ARF) Movement", in which at least 25,00 youth will participate, by September 30, 2009.

Annual Activity Objective: Subawardee will involve at least 150 schools, organizations and families, by September 30, 2006.

- Activities include: ARF Youth Physical Activity and Nutrition Days in 7 areas across the state, conduct train-the-trainer sessions, develop sustainability plan with local health departments, develop training DVD, pilot 6-week ARF-based youth physical activity and nutrition program with the Urban Indian Center.

PROGRAM PROFILE

1. Program Title: PHYSICAL ACTIVITY AND NUTRITION PROGRAM

2. Total Block Grant Funds to Program:

Current Year:	
a. HO 19-2	$42,075
b. HO 19-3	$67,075
c. HO 22-1	$87,076
d. HO 22-6	$42,076
Total:	$238,302

Prior Year:	
a. HO 19-2	$0
b. HO 19-3	$0
c. HO 22-1	$0
d. HO 22-6	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 19-2	$12,000
b. HO 19-3	$4,000
c. HO 22-1	$12,000
d. HO 22-6	$4,500
Total:	$32,500

4. Total FTE's for Program:

Number:	
a. HO 19-2	0.37
b. HO 19-3	0.53
c. HO 22-1	0.52
d. HO 22-6	0.38
Total:	1.80

Description (Optional): The PHHS Block Grant supports about 0.75 FTEs within the NHHSS, as well as a very small part of staff at local health departments, addressing the selected nutrition and physical activity objectives.

HEALTH OBJECTIVE PROFILE for HO 19-2 Obesity in adults

5a. National Health Objective: 19-2 Obesity in adults

Reduce the proportion of adults who are obese.
23 percent of adults aged 20 years and older were identified as obese in 1988-94 (age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

To reduce the proportion of Nebraska adults, aged 18 and older, who report heights and weights that place them in the "obese" category (Body Mass Index BMI of 30 or more) to no more than 15 percent, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

7a. Target and Disparate Population Numbers:

Target Number: 731,392
Disparate Number: 267,336

8a. HO Dollars/FTE's:

(1). Total Current Year: $42,075
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.37
(5). Amount of $'s to Local Entities for HO: $12,000

Description (Optional): PHHS Block Grant funds are used to support staff at the local level. In addition, subawards will be made to:

- the Nebraska Dietetic Association to support a speaker,
- to the Public Health Association of Nebraska to support a conference on environmental policy,
- Nebraska Worksite Wellness Organizations for training sessions on environmental change, and
- a Local Public Health Departments to implement a project that promotes a safe, walkable built environment and pilot a community based "All Recreate Friday" program.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 19-2 10-49% - Partial source of funding

10a. Block Grant Role:

HO 19-2 Supplemental Funding

Description (Optional): The PHHS Block Grant supports education and technical assistance provided by the staff of the NHHSS, working on nutrition and physical activity issues.

11a. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

HEALTH OBJECTIVE PROFILE for HO 19-3 Overweight or obesity in children and adolescents

5b. National Health Objective: 19-3 Overweight or obesity in children and adolescents

Reduce the proportion of children and adolescents who are overweight or obese.
Children aged 6 to 11 was 11 percent in 1988-94. Adolescents aged 12 to 19 was 11 percent in 1988-94.

6b. State Health Objective(s):

To reduce the proportion of Nebraska children and youth who are overweight or obese, to no more than 3% among those 12 to 19 years of age, by September 30, 2010.

(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May, 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

7b. Target and Disparate Population Numbers:

Target Number: 106,000
Disparate Number: 50,000

8b. HO Dollars/FTE's:

(1). Total Current Year: $67,075
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.53
(5). Amount of $'s to Local Entities for HO: $4,000

Description (Optional): PHHS Block Grant funds are used to support staff at the state level. In addition, funds will be used to support:

- a speaker for the Nebraska Academy of Family Physicians annual conference,
- conference costs for the Nebraska Association for Health, Physical Education, Recreation and Dance,
- stipends to the Native American Tribes to implement "Gift of Heart Health" curriculum.

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 19-3 10-49% - Partial source of funding

10b. Block Grant Role:

HO 19-3 Supplemental Funding

Description (Optional): The PHHS Block Grant supports education and technical assistance provided by the staff of the NHHSS, working on nutrition and physical activity issues, as well as a small portion of activities carried out by the staff of local health departments and contracted by the Diabetes Program.

11b. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

HEALTH OBJECTIVE PROFILE for HO 22-1 Physical Activity in Adults

5c. National Health Objective: 22-1 Physical Activity in Adults

Reduce the proportion of adults who engage in no leisure-time physical activity
40 percent of adults aged 18 years and older engaged in no leisure-time physical activity in 1997. (age adjusted to the year 2000 standard population).

6c. State Health Objective(s):

To increase the percentage of Nebraska adults, aged 18 and older, who engaged in regular and sustained physical activity in the preceding month to at least 30 percent, by September 30, 2010.

[Baseline: 20 percent in 1999]
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

7c. Target and Disparate Population Numbers:

Target Number: 1,008,816
Disparate Number: 340,475

8c. HO Dollars/FTE's:

(1). Total Current Year: $87,076
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.52
(5). Amount of $'s to Local Entities for HO: $12,000

Description (Optional): PHHS Block Grant funds are used to support staff at the local level. In addition, subawards will be made to:

- the Nebraska Dietetic Association to support a speaker,
- to the Public Health Association of Nebraska to support a conference on environmental policy,
- Nebraska Worksite Wellness Organizations for training sessions on environmental change, and
- a Local Public Health Departments to implement a project that promotes a safe, walkable built environment and pilot a community based "All Recreate Friday" program.

9c. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 22-1 10-49% - Partial source of funding

10c. Block Grant Role:

HO 22-1 Supplemental Funding

Description (Optional): The PHHS Block Grant supports education and technical assistance provided by the staff of the NHHSS, working on nutrition and physical activity issues, as well as a small portion of activities carried out by the staff of local health departments.

11c. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

HEALTH OBJECTIVE PROFILE for HO 22-6 Physical Activity in Children and Adolescents

5d. National Health Objective: 22-6 Physical Activity in Children and Adolescents

Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
27 percent of students in grades 9 through 12 engaged in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days in 1999.

6d. State Health Objective(s):

To increase the proportion of adolescents in grades 9-12 in Nebraska who engage in moderate physical activity for at least 30 minutes on 5 or more days of the previous 7 days to at least 35 percent, by September 30, 2010.

(Baseline: 28 percent in 1999)
(This objective was taken from "Nebraska 2010 Health Goals and Objectives", published May 2002)

The Physical Activity and Nutrition Program (PAN) aims to build infrastructure through policy and environmental strategies for physical activity and nutrition through multiple channels -- community, school, worksite, and faith organizations.

7d. Target and Disparate Population Numbers:

Target Number: 189,967
Disparate Number: 189,966

8d. HO Dollars/FTE's:

(1). Total Current Year: $42,076
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.38
(5). Amount of $'s to Local Entities for HO: $4,500

Description (Optional): PHHS Block Grant funds are used to support staff at the state level. In addition, funds will be used to support:

- a speaker for the Nebraska Academy of Family Physicians annual conference,
- conference costs for the Nebraska Association for Health, Physical Education, Recreation and Dance,
- stipends to the Native American Tribes to implement "Gift of Heart Health" curriculum.

9d. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 22-6 10-49% - Partial source of funding

10d. Block Grant Role:

HO 22-6 Supplemental Funding

Description (Optional): The PHHS Block Grant supports education and technical assistance provided by the staff of the NHHSS, working on nutrition and physical activity issues, as well as a small portion of activities carried out by the staff of local health departments.

11d. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

State Program Title: PUBLIC HEALTH INFRASTRUCTURE PROGRAM

State Program Strategy:

ⓘ The Nebraska Health and Human Services System (NHHSS) dedicates a portion of its funds to supporting and strengthening Nebraska's Public Health Infrastructure.

⏩ **Strategies selected for the PHHSBG-funded portion include: assure adequate surveillance systems, data collection and analysis, strategic planning and performance standards, and trained workforce, which are critical to the success of any of the other activities carried out by the NHHSS.**

⏵ The following is taken from *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State,* published Nov 1999, NHHSS, and from a description of the process within the Public Health Program of NHHSS.

A new vision:

As the 21st Century begins, the vision for public health is to have healthy and productive individuals, families and communities across Nebraska. In order to achieve this vision, strong and effective partnerships will be formed with state, local, and tribal governments, community-based coalitions, non-profit and volunteer organizations, academic institutions, the business community, hospitals, physicians, insurance organizations, minority and environmental organizations, and many others.

These partnerships will be effective in improving health status for all population groups and eliminating disparities for racial/ethnic minorities and the other underserved populations. Financial, geographic, and cultural barriers will be eliminated through a more integrated health and medical delivery system.

This system will have a greater focus on quality, accountability, and prevention. Finally, a stronger public health infrastructure will be developed that includes more local health departments and community health system organizations. This enhanced infrastructure will provide key public health functions and activities and support greater local decision-making based on an effective community planning process.

Core functions: Assessment, Policy Development, Assurance:

The assessment function involves the collection and analysis of information to identify important health problems. These problems may involve water quality, the use of tobacco and alcohol, or the disparity in health status between the white population and racial/ethnic minorities. Once the important health problems have been identified, the policy development function focuses on building coalitions that can develop and advocate for local and state health policies to address the high priority health issues. The assurance function makes state and local health agencies as well as health professionals (e.g., physicians) responsible for assuring that programs and services are available to meet the high priority needs of the population.

Public Health Infrastructure Development:

The first component of infrastructure development is to upgrade the skills and abilities of the current

workforce and create new training and educational programs for new workers.

The second component involves developing more regional and county health departments and other flexible organizational structures that allow communities to select the "right" model for them.

The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link databases together (e.g., Medicaid encounter data with birth records) and making data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data (e.g., mental health and substance abuse, environmental health, etc.) that will more clearly identify health needs.

The final component of infrastructure development is more financial resources. Greater state-level support either through the newly created Excellence in Health Care Trust Fund or other revenue sources is needed to provide ongoing funding for local and state level capacity development

National Health Objective: **HO 23-2 Public health access to information and surveillance data**

State Health Objective(s):

To assure development of data systems and means of access to those data in every local health department, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
The Nebraska Health and Human Services System must collect and analyze data in order to track achievement of objectives and complete reporting for the PHHS Block Grant. It is logical that a portion of PHHS Block Grant funds, allocated to Nebraska, be used to support the Data and Information Systems Health Objective.

"The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link databases together (e.g., Medicaid encounter data with birth records) and making data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data (e.g., mental health and substance abuse, environmental health, etc.) that will more clearly identify health needs."

[Source of preceding paragraph: *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State]*

Target Population:

Nebraska Defines the Target Population as the users of data, including the public and local governmental agencies and health organizations.(estimated number)

Group(s) Served: Local Health Departments, General Public Data Users, Community Based Organizations, Health Care Practitioners, Boards of Health, Coalitions/Partnerships, Task Forces, Community Planners, Policy Makers, Educational Institutions, Health Care Delivery Organizations, Faith Based Organizations, Business/Merchants

Disparate Population:

Nebraska defines the Disparate Population staff of selected local health departments.

Group(s) Served: Local Health Departments

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: To assure the availability of data to citizens and public health professionals in one urban county, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will continue to develop comprehensive local health data bases and information infrastructure to inform health program planning and resource allocation, provide technical assistance to staff, and issue reports, and continue implementation of Geographic Information System (GIS), by September 30, 2006.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To assure the availability of data to citizens and public health professionals in one urban county, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will provide technical assistance to staff and will produce and distribute reports, by September 30, 2006.

National Health Objective: HO 23-4 Data for all population groups

State Health Objective(s):

To assure development of data systems, with emphasis on availability of data on special populations, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
The Nebraska Health and Human Services System must collect and analyze data in order to track achievement of objectives and complete reporting for the PHHS Block Grant. It is logical that a portion of PHHS Block Grant funds allocated to Nebraska be used the Data and Information Systems Health Objective.

"The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link databases together (e.g., Medicaid encounter data with birth records) and making data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data (e.g., mental health and substance abuse, environmental health, etc.) that will more clearly identify health needs."

[Source of the preceding paragraph: *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State]*

Target Population:

Nebraska defines the Target Population as the users of data, including the public and local governmental agencies and health organizations.

Group(s) Served: Local Health Departments, General Public Data Users, Community Based Organizations, Health Care Practitioners, Boards of Health, Coalitions/Partnerships, Task Forces, Community Planners, Policy Makers, Educational Institutions, Health Care Delivery Organizations, Faith Based Organizations

Disparate Population:

Nebraska defines its Disparate Population as the staff of new local health entities, boards of health and

interested citizens (estimated number).

Group(s) Served: Local Health Departments, Boards of Health, Community Planners

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: To assure the availability of data on special populations, including racial and ethnic minorities, youth and elderly, urban and rural populations, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain and develop data bases, provide technical assistance to staff, and issue reports, by September 30, 2006.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To assure the availability of data on special populations, including racial and ethnic minorities, youth and elderly, urban and rural populations, by September 30, 2009.

Annual Activity Objective: Subawardee will maintain and develop data bases, provide technical assistance to staff, and issue reports, by September 30, 2006.

National Health Objective: HO 23-5 Data and Information systems

State Health Objective(s):

To maintain and improve Nebraska's health surveillance system, including needed data collection and analysis, and development of health status indicators and make information available to health planners, health program staff, medical and health professionals, community coalitions, and the public, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
The Nebraska Health and Human Services System must collect and analyze data in order to track achievement of objectives and complete reporting for the PHHS Block Grant. It is logical that a portion of PHHS Block Grant funds allocated to Nebraska be used the Data and Information Systems Health Objective.

"The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link databases together (e.g., Medicaid encounter data with birth records) and making data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data (e.g., mental health and substance abuse, environmental health, etc.) that will more clearly identify health needs."

[Source of the precedng paragraph: *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State]*

Target Population:

Nebraska defines its Target Population as the potential users of the data produced (estimated number).

Group(s) Served: Local Health Departments, General Public Data Users, Community Based Organizations, Health Care Practitioners, Boards of Health, Coalitions/Partnerships, Task Forces, Community Planners, Policy Makers, Educational Institutions, Health Care Delivery Organizations, Faith Based Organizations

Disparate Population:

Nebraska defines its Disparate Population as the staff of new local health entities, boards of health and interested citizens (estimated number).

Group(s) Served: Local Health Departments, Boards of Health, Community Planners

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: To maintain the surveillance system and improve the capacity to collect, analyze and report data for disparate populations, by September 30, 2009.

Annual Activity Objective: Subawardees will maintain communications between data providers and data users, and work with epidemiologist to improve the surveillance system, by September 30, 2006.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To maintain a system with capacity to provide needed information to all interested persons, by September 30, 2009.

Annual Activity Objective: Subawardees will generate and distribute reports of surveillance system data by both printed and electronic means, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To maintain the surveillance system and improve the capacity to collect, analyze and report data for disparate populations, by September 30, 2009.

Annual Activity Objective: Subawardees will assure availability of pertinent data to audiences developing health improvement plans, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To collect and analyze data about the effect of programs on the health status of Nebraskans, by September 30, 2009.

Annual Activity Objective: Subawardees will provide needed information about health status and program performance, by September 30, 2006.

National Health Objective: HO 23-10 Continuing education and training

State Health Objective(s):

To maintain and improve the quality of public health workers in Nebraska by providing needed training in the Essential Public Health Services, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
Providing adequate and timely training to health professionals will go a long way toward achieving a quality Public Health System for Nebraska.

Target Population:

Nebraska defines the Target Population as organizations and agencies involved in delivering services to minority populations, including the staff of all existing local health agencies, as well as a portion of the staff of the NHHSS-Services agency.
(Estimated number)

Group(s) Served: Local Health Departments, High Risk Populations, Community Based Organizations, Health Care Practitioners, Boards of Health, Coalitions/Partnerships, Task Forces, Community Planners, Policy Makers, Educational Institutions, Health Care Delivery Organizations, Faith Based Organizations

Disparate Population:

Nebraska defines as Disparate Population the staff of local/regional health agencies. (Estimated number)

Group(s) Served: Local Health Departments, Boards of Health

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To develop and maintain communications and evaluation capacity, by September 30, 2009.

Annual Activity Objective: Subawardees will communicate expectations and provide technical assistance, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To assure the development of policies and standards for culturally and linguistically appropriate and effective continuing education across the state, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical assistance and models for development of culturally and linguistically appropriate programs and services, by September 30, 2006.

Essential Service 8 - Assure competent workforce:

Desired Impact Objective: To sponsor training and education opportunities for community partners and responders and participate in staff training, in order to assure quality of activities developed, by September 30, 2009.

Annual Activity Objective: Subawardee will prepare materials, and make arrangements for at least five training opportunities for community partners and responders, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To monitor performance of projects for potential improvement in performance, by September 30, 2009.

Annual Activity Objective: Subawardee will collect reports and pertinent data about program performance, by September 30, 2006.

National Health Objective: HO 23-11 Performance standards

State Health Objective(s):

To develop competency among local/district health department staff in the essential public health services and in conducting the local performance standards, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
Providing adequate and timely training to health professionals will go a long way toward achieving a quality Public Health System for Nebraska.

Target Population:

Nebraska defines the Target Population as organizations and agencies involved in delivering health services, including the staff of all existing local health agencies, as well as a portion of the staff of the NHHSS-Services agency.
(Estimated number)

Group(s) Served: Local Health Departments, Community Based Organizations

Disparate Population:

Nebraska defines as Disparate Population the staff of local/regional health agencies, and the core team of responders. (Estimated number)

Group(s) Served: Local Health Departments, Community Based Organizations

ESSENTIAL SERVICES

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain partnerships with agencies and organizations involved in the development of new multi-county health departments, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work with coalitions, community agencies and established health agencies to assure the viability of newly formed multi county health departments, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To assure the development of policies and standards for culturally and linquistically appropriate and effective continuing education across the state, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical assistance and models for development of cultrually and linquistically appropriate programs and services, by September 30, 2006.

National Health Objective: HO 23-12 Health improvement plans

State Health Objective(s):

To develop and implement coordinated and comprehensive health improvement plans for Nebraska and facilitate development of health improvement plans for local areas, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.
An important part of strengthening Nebraska's public health infrastructure is developing standard, comprehensive and useful health improvement plans.

Target Population:

Nebraska defines the Target Population as the staff of all existing and potential local health entities.

Group(s) Served: Local Health Departments

Disparate Population:

Nebraska defines the Disparate Population the same as the Target Population.

Group(s) Served: Local Health Departments

ESSENTIAL SERVICES

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To build relationships with state and local agencies involved in strengthening public health infrastructure in Nebraska, by September 30, 2009.

> **Annual Activity Objective:** Subawardees will maintain and build partnerships to work toward comprehensive plan development, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To facilitate development of health improvement plans in all local health agencies which are coordinated with Nebraska 2010, by September 30, 2009.

Annual Activity Objective: Subawardees will work directly with local health entities, and health coalitions to facilitate the development of comprehensive plans for all agencies, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To collect and analyze data about the development of health improvement plans, by September 30, 2009.

Annual Activity Objective: Subawardee will collect and analyze reports of local entities, by September 30, 2006.

National Health Objective: HO 23-15 Model statutes related to essential public health services

State Health Objective(s):

To assure implementation of *Model State Public Heatlh Act: A Tool for Assessing Public Health Laws,* by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.

An important part of strengthening Nebraska's public health infrastructure is developing standard, comprehensive and useful health improvement plans.

Target Population:

Nebraska defines Target Population as county officials, health agency staff, and interested citizens.

Group(s) Served: Local Health Departments, General Public Data Users, Community Based Organizations, Community Planners

Disparate Population:

Nebraska defines Disparate Population the same as the Target Population.

Group(s) Served: Local Health Departments, General Public Data Users, Community Based Organizations, Community Planners

ESSENTIAL SERVICES

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To maintain partnerships with agencies and organizations involved in the development of new multi-county health departments, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work with coalitions, community agencies and established health agencies to assure the viability of newly formed multi county health departments, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To develop and implement comprehensive strategic community health plans in cooperation with employees and funded projects, by September 30, 2009.

Annual Activity Objective: Subawardees will facilitate the development of needed health-related and environmental policies, ensuring the viability of new multi-county health agencies, by September 30, 2006.

PROGRAM PROFILE

1. Program Title: PUBLIC HEALTH INFRASTRUCTURE PROGRAM

2. Total Block Grant Funds to Program:

Current Year:

a. HO 23-2	$25,000
b. HO 23-4	$47,243
c. HO 23-5	$28,971
d. HO 23-10	$48,145
e. HO 23-11	$65,000
f. HO 23-12	$75,000
g. HO 23-15	$10,000
Total:	$299,359

Prior Year:

a. HO 23-2	$0
b. HO 23-4	$0
c. HO 23-5	$0
d. HO 23-10	$0
e. HO 23-11	$0
f. HO 23-12	$0
g. HO 23-15	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 23-2	$25,000
b. HO 23-4	$0
c. HO 23-5	$0
d. HO 23-10	$0
e. HO 23-11	$0
f. HO 23-12	$30,000
g. HO 23-15	$0
Total:	$55,000

4. Total FTE's for Program:

Number:

a. HO 23-2	0.25
b. HO 23-4	0.35
c. HO 23-5	0.52
d. HO 23-10	0.40

e. HO 23-11	0.50
f. HO 23-12	0.60
g. HO 23-15	0.20
Total:	2.82

Description (Optional): PHHSBG funds support NHHSS staff, and a portion of the staff of a local health department, devoted to improving Public Health Infrastructure in Nebraska.

HEALTH OBJECTIVE PROFILE for HO 23-2 Public health access to information and surveillance data

5a. National Health Objective: 23-2 Public health access to information and surveillance data

Increase the proportion of Tribal, State, and local public health agencies that have made information available to the public in the past year on the Leading Health Indicators, Health Status Indicators, and Priority Data Needs.
An operation definition has not been specified.

6a. State Health Objective(s):

To assure development of data systems and means of access to those data in every local health department, by September 30, 2010.

7a. Target and Disparate Population Numbers:

Target Number: 1,000
Disparate Number: 50

8a. HO Dollars/FTE's:

(1). Total Current Year: $25,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.25
(5). Amount of $'s to Local Entities for HO: $25,000

Description (Optional): PHHSBG funds support epidemiology work at one large local health department.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-2 10-49% - Partial source of funding

10a. Block Grant Role:

HO 23-2 Supplemental Funding

Description (Optional): PHHSBG funds support a portion of epidemiology work done at one local health department (LLCHD).

11a. 10 Essential Services

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate

HEALTH OBJECTIVE PROFILE for HO 23-4 Data for all population groups

5b. National Health Objective: 23-4 Data for all population groups

Increase the proportion of population-based Healthy People 2010 objectives for which national data are available for all population groups identified for the objective.
11 percent of Healthy People 2010 population-based objectives or lettered subobjectives have baselines for which national data are available for all population groups identified in 2000.

6b. State Health Objective(s):

To assure development of data systems, with emphasis on availability of data on special populations, by September 30, 2010.

7b. Target and Disparate Population Numbers:

Target Number: 5,000
Disparate Number: 75

8b. HO Dollars/FTE's:

(1). Total Current Year: $47,243
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.35
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): PHHS Block Grant funds support a portion of one staff position and one contractor.

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-4 10-49% - Partial source of funding

10b. Block Grant Role:

HO 23-4 Supplemental Funding

Description (Optional): PHHSBG support a portion of the data system of NHHSS, including a portion of the (contract) cost of operating the Behavioral Risk Factor Surveillance System, and a portion of the work done for and by the staff of the Research and Performance Measurement section, NHHSS.

11b. 10 Essential Services

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate

HEALTH OBJECTIVE PROFILE for HO 23-5 Data and Information systems

5c. National Health Objective: 23-5 Data and Information systems

Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data - especially for select populations - are available at the Tribal, State, and Local levels.
An operation definition has not been specified.

6c. State Health Objective(s):

To maintain and improve Nebraska's health surveillance system, including needed data collection and analysis, and development of health status indicators and make information available to health planners, health program staff, medical and health professionals, community coalitions, and the public, by September 30, 2010.

7c. Target and Disparate Population Numbers:

Target Number: 5,000
Disparate Number: 75

8c. HO Dollars/FTE's:

(1). Total Current Year: $28,971
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.52
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): PHHS Block Grant funds are used to support a portion of the cost of data management and reporting at NHHSS.

9c. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-5 10-49% - Partial source of funding

10c. Block Grant Role:

HO 23-5 Supplemental Funding

Description (Optional): The PHHS Block Grant supports a portion of the data collection, analysis and reporting for the surveillance system of the NHHSS, including and a portion of the work done by staff

of the Research and Performance Measurement section and the Office of Minority Health, NHHSS.

11c. 10 Essential Services

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate
Essential Service 5 - Develop policies and plans
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 23-10 Continuing education and training

5d. National Health Objective: 23-10 Continuing education and training

Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees. An operation definition has not been specified.

6d. State Health Objective(s):

To maintain and improve the quality of public health workers in Nebraska by providing needed training in the Essential Public Health Services, by September 30, 2010.

7d. Target and Disparate Population Numbers:

Target Number: 1,500
Disparate Number: 200

8d. HO Dollars/FTE's:

(1). Total Current Year: $48,145
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.40
(5). Amount of $'s to Local Entities for HO: $0

Description (Optional): PHHS Block Grant funds are used to support a portion of the cost of data management and reporting at NHHSS.

9d. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-10 10-49% - Partial source of funding

10d. Block Grant Role:

HO 23-10 Supplemental Funding

Description (Optional): The PHHSBG supports a portion of the continuing education and training carried out through the Office of Public Health.

11d. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 5 - Develop policies and plans
Essential Service 8 - Assure competent workforce
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 23-11 Performance standards

5e. National Health Objective: 23-11 Performance standards

Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.
An operation definition has not been specified.

6e. State Health Objective(s):

To develop competency among local/district health department staff in the essential public health services and in conducting the local performance standards, by September 30, 2010.

7e. Target and Disparate Population Numbers:

Target Number: 15,000
Disparate Number: 200

8e. HO Dollars/FTE's:

(1). Total Current Year: $65,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $0
(4). Number of FTE's for HO: 0.50
(5). Amount of $'s to Local Entities for HO: $0

9e. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-11 10-49% - Partial source of funding

10e. Block Grant Role:

HO 23-11 Supplemental Funding

Description (Optional): PHHSBG funds are used to support NHHS staff who provided technical assistance and training to local/district health department staff.

11e. 10 Essential Services

Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

HEALTH OBJECTIVE PROFILE for HO 23-12 Health improvement plans

5f. National Health Objective: 23-12 Health improvement plans

Increase the proportion of Tribes, States, and the District of Columbia that have a health improvement plan and increase the proportion of local jurisdictions that have a health improvement plan linked with their State plan.
78 percent of states, including the District of Columbia have a health improvement plan in 1997. 32 percent of local jurisdictions had a health improvement plan linked with their State plan in 1992-93.

6f. State Health Objective(s):

To develop and implement coordinated and comprehensive health improvement plans for Nebraska and facilitate development of health improvement plans for local areas, by September 30, 2010.

7f. Target and Disparate Population Numbers:

Target Number: 75
Disparate Number: 75

8f. HO Dollars/FTE's:

(1). Total Current Year: $75,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $25,000
(4). Number of FTE's for HO: 0.60
(5). Amount of $'s to Local Entities for HO: $30,000

Description (Optional): Funds are to be awarded to District Health Departments to evaluate past health improvement plans, update plans using MAPP process and conduct local CDC governance performance standards.

9f. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-12 10-49% - Partial source of funding

10f. Block Grant Role:

HO 23-12 Supplemental Funding

Description (Optional): PHHS Block Grant funding supports a portion of the effort to develop plans,

and standards at the state and local level.

11f. 10 Essential Services

Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 23-15 Model statutes related to essential public health services

5g. National Health Objective: 23-15 Model statutes related to essential public health services

Increase the proportion of Federal, Tribal, State, and local public jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws ensure the delivery of essential public health services.
An operation definition has not been specified.

6g. State Health Objective(s):

To assure implementation of *Model State Public Heatlh Act: A Tool for Assessing Public Health Laws,* by September 30, 2010.

7g. Target and Disparate Population Numbers:

Target Number: 5,000
Disparate Number: 5,000

8g. HO Dollars/FTE's:

(1). Total Current Year: $10,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.20
(5). Amount of $'s to Local Entities for HO: $0

9g. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-15 10-49% - Partial source of funding

10g. Block Grant Role:

HO 23-15 Supplemental Funding

Description (Optional): PHHSBG funds help support NHHSS staff involved in developing the document listed in the State Objective.

11g. 10 Essential Services

Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans

State Program Title: **SPECIAL POPULATIONS PROGRAM**

State Program Strategy:

The Nebraska Health and Human Services System (NHHSS) operates a variety of programs and services in a variety of settings aimed at specific segments of Nebraska's population. Some of those services are mentioned below:

Strategies selected for the PHHSBG-funded Special Populations Program focus public health prevention activities on three sites or populations : worksites, communities and racial/ethnic minorities.

Other NHHSS Programs:

Office of Minority Health and Human Services
The Office of Minority Health and Human Services (OMHHS) represents and advances the interests of people of color for the purpose of reducing the disparity that exists between the health status of racial/ethnic minorities and non-minorities in Nebraska.

Central issues are to improve access to health services for racial/ethnic minorities; improve data collection strategies; increase racial/ethnic minority representation in science and health professions; develop relevant and comprehensive research agenda; and expand community-based health promotion and disease prevention outreach efforts.

The Nebraska Health and Human Services System (HHSS) serves a pivotal role for federal, state, tribal, and local efforts as these groups work together to improve the health status of the state's racial and ethnic minority populations. Eliminating disparities requires a strong partnership among traditional and non-traditional public health-related organizations.

National Health Objective: **HO 7-5 Worksite health promotion programs**

State Health Objective(s):

To improve health status of workers and protect the worksite environment in Nebraska, by September 30, 2010.

State Health Problem:

Only a few Nebraska worksites offer health promotion programs to their employees, leaving many opportunities to reach working-age adults with health promotion and prevention messages, as well as services such as health risk appraisal and counseling to lower risk.

Target Population:

Nebraska defines the Target Population as workers served by one local health departments.

This number represents the workers at approximately 80 worksites. An additional audience for health messages and services are the family members of those workers, or at least an additional 100,000 persons.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as about half of the Target Population, who have at least two risk factors for development of health problems and disability.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To assure accurate information on relevant health topics is provided to employees at targeted worksites, by September 30, 2009.

Annual Activity Objective: Subawardee will design or obtain materials, distribute materials, facilitate counseling on risk reduction to 50,000 employees of 80 businesses in one county, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To assure adequate implementation of worksite wellness and to document progress, by September 30, 2009.

Annual Activity Objective: Subawardee will design methods, implement data collection and analysis and issue reports of progress, by September 30, 2006.

National Health Objective: **HO 7-10 Community health promotion programs**

State Health Objective(s):

To improve the health status of Nebraska's communities, by September 30, 2010.

State Health Problem:

Some of the challenges in improving the health of communities in Nebraska are:

⏩ Large elderly population. Older Nebraskans represent a growing portion of the population, projected to reach 320,751 by the year 2020, 15.8 percent of the total population in that year. 2000 census figures show 232,195 (13.6 percent of the population) was over the age of 65. This compares to 12.4 percent at the national level.
⏩ Rapidly expanding minority population. According to the Nebraska Databook of the Nebraska Department of Economic Development, the projected growth of Nebraska's minority communities will greatly exceed the growth of the white population over the next quarter century. From July 2000 to July 2025, the total population is projected to grow more than 13 percent, the white population is projected to grow by about 9.9 percent, the Black population is projected to grow by nearly 51.4 percent , the American Indian population by nearly 56 percent, the Asian population by 82 percent and the Hispanic population by 82 percent. It is estimated that the Hispanic population will be the largest minority group in Nebraska by 2025.
⏩ Large geographic area. Nebraska's total area, including land and water is 77,358 square miles, ranking it as the 16th largest state. Nebraska's land area alone is 76,878 square miles, ranking it the 15th largest state.
⏩ Uneven population distribution. More than three-fourths of Nebraska's live in the eastern third of the state. More than half of the population lives in Nebraska's six largest counties. (Nebraska 2000 Census estimate 1,711,263)
⏩ Sparsely populated counties. Many central and western Nebraska counties are sparsely populated. According to 2000 Census figures, 33 of Nebraska's 93 counties had fewer than 6 people per square mile, designating them as "frontier" counties. Additionally,19 counties had between 6 and 12 people per square mile, and 22 counties had between 13 and 24 people per square mile. Only 19 counties had 25 or more people per square mile . Of the most populous 19 counties, only four had more people per square mile than the United States as a whole. Nebraska as a whole had 22.3 people per square mile, compared to 79.6 people per square mile in the United States as a whole.

Target Population:

Nebraska defines the Target Population as the number of people living in the three counties offering community health promotion programs: Scotts Bluff, Saunders, and Merrick.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as about one half of the Target Population, having two or more risk factors for development of health problems or disability.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: To reduce the number of youth in grades 9-12 who drink and drive to less than 18 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work to create a community consensus that clearly states that underage alcohol use is illegal, unhealthy and unacceptable, by September 30, 2006.

Desired Impact Objective: To reduce the number of youth in grades 9-12 who ride in a vehicle with someone who has been drinking to less than 35 percent, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will work to create a community consensus that clearly states that underage alcohol use is illegal, unhealthy and unacceptable, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To assure the development of appropriate administrative policy for monitoring subawardees, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will perform administrative duties, prepare required documents and report progress, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To assure adequate development of public health programs in Nebraska, by September 30, 2009.

Annual Activity Objective for Desired Impact Objective: Subawardee will monitor the implementation of 11 projects funded through competitive application, 16 projects operated by

NHHSS programs, and 4 discretionary projects, by September 30, 2006.

National Health Objective: HO 7-11 Culturally appropriate community health promotion programs

State Health Objective(s):

To improve the health status of Nebraskans who are members of racial and ethnic minorities, eliminating the disparity in health status compared to the white population, by September 30, 2010.

State Health Problem:

Among the health problems targeted by the Nebraska Health and Human Services System, are the weaknesses in Nebraska's public health infrastructure and the substantial disparities in health status among Nebraska's racial and ethnic minority groups when compared to the majority population of Nebraska.

Strengthening Nebraska's public health infrastructure will facilitate the planning and provision of health services in the community, school and worksite, and narrow the disparity in health status between the minority and majority populations of Nebraska.

Population growth:

The Hispanic or Latino population in Nebraska is the largest and most rapidly expanding minority group in the state. Between 1990 and 2000, the Hispanic or Latino population increased by 155.4 percent. Thus the growth in the Hispanic population from 36,969 in 1990 to 94,425 in 2000, accounted for 70.6 percent of the total growth of the racial and ethnic minority population. Hispanics now make up more than 5.5 percent of Nebraska's total population.

During the same decade, other minority populations experienced smaller increases:

* the Asian population grew by 8.5 percent, numbering 22,767 or 1.3% of Nebraska's total population;
* African American population increased by 6.5 percent, numbering 68,541 or 4.0 percent of Nebraska's total population;
* Native American population grew by 2.5 percent, numbering 14,896 or 0.9 percent of Nebraska's total population.

The health implications and related needs of the growing racial and ethnic minority population will have an impact on the health care delivery system in the state.

Health Disparities:

* The average life expectancy for the state of Nebraska in the three-year period, 2000-2002 was 78.3 years for whites, 71.6 years for African Americans and 67.9 years for Native Americans.
* In Nebraska, during 1998-2002, heart disease in all forms accounted for a total of 21,804 deaths. Of the total 4,094 deaths among the racial and ethnic minority population, heart disease accounted for 20.7 percent or a total of 848 deaths.
* Of the total 4,094 deaths among the racial and ethnic minority population, stroke accounted for 6.0 percent or 247 minority deaths.
* Heart disease is the leading cause of death among African Americans, Native Americans, and

whites in Nebraska. Native Americans have the highest rate of mortality (435.7 deaths per 100,000 population) and are 1.9 times as likely to die of heart disease as whites. African Americans have the second highest rate of heart disease mortality (280.4) and are 1.2 times as likely to die of the disease as whites.

* The death rate due to stroke is 1.6 times as high for African Americans and 1.3 times as high for Native Americans as the rate for white Nebraskans.
* In the five-year period, 1998-2002, cancer was the leading cause of death among Asian and Hispanic Americans. In the same period, cancer was the second leading cause of death among African Americans, Native Americans, and white Nebraskans. African Americans are 1.4 times and Native Americans, 1.2 times more likely to die from cancer than white Nebraskans.
* In 2002, Native Americans (50.9 percent – based on small number), African Americans (33.4 percent) and Hispanic Americans (27.2 percent), and 5.5 percent of Asian Americans 18 years and older, were more likely than all of Nebraskans (23.2 percent) to be obese.
* African Americans have the highest number of low weight births (129.1 per 1,000 live births) in Nebraska. Both Native Americans (115.2 births per 1,000 adolescent girls) and Hispanic Americans (110.7) have high rates of teen births.
* Native Americans have the highest rates for unintentional injury (107.7/100,000) deaths and motor vehicle fatalities (43.6/100,000) of any racial or ethnic group in Nebraska for 1998-2002.
* Native Americans in the state are 4.9 times more likely to die of diabetes-related causes, than white Nebraskans. The diabetes-related death rate for African Americans is 2.4 times greater and the rate for Hispanic Americans is 1.6 times greater than the rate for white Nebraskans.
* Female African Americans are 2.9 times more likely to die from diabetes-related causes than their white counterparts.
* At the rate of 81.8 deaths per 100,000 Native Americans are 13.6 times more likely to die from cirrhosis of the liver than whites.
* African Americans and Native Americans in Nebraska have the highest incidence of HIV/AIDS, with African Americans having a relative risk of 11.2, and the Native Americans, 5.4 and Hispanics, 4.7.

[Source: "Health Status of Racial and Ethnic Minorities in Nebraska", Sept 2003, NHHSS]

Target Population:

Nebraska defines the Target Population as the number of minority persons in Nebraska, according to the 2000 census.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as the same as the Target Population for this health objective.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: To maintain the surveillance system and improve the capacity to collect, analyze and report data for disparate populations, by September 30, 2009.

Annual Activity Objective: Subawardee will publish the next report -- on substance abuse in Native Americans and complete the Nebraska Minority BRFSS reports for Douglas, Sarpy, Scotts Bluff, Dawson, Lincoln, Box Butte, Thurston and Sheridan Counties, by September 30. 2006.

Annual Activity Objective: Subawardee will collaborate with the Indian Health Service and Universities to establish an Epidemiology Center for Native American health issues, by September 30, 2006.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: To assure continuing education to develop competency among public health employees, especially concerning minority health in Nebraska, by September 30, 2009.

Annual Activity Objective: Subawardee will conduct cultural competency training for public health workers and convene a statewide Minority Health Conference in collaboration with the Nebraska Minority Public Health Association and the Public Health Association of Nebraska, by September 30, 2006.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: To facilitate the development and implementation of culturally and linguistically appropriate minority health programs and services, by September 30, 2009.

Annual Activity Objective: Subawardee will provide technical assistance to the directors and boards of new district health departments in establishing culturally and linguistically appropriate programs and services, by September 30, 2006.

Annual Activity Objective: Subawardee will provide leadership in the development of a minority health improvement plan at the state level and provide technical assistance for action plans at the local level, by September 30, 2006.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: To assure current programs have implemented culturally competent and linguistically appropriate programs and services, by September 30, 2009.

Annual Activity Objective: To evaluate ongoing Minority Health Initiative subgrantees, and assure compliance by HHSS with the Culturally and Linguistically Appropriate Services (CLAS) standards, by September 30, 2006.

National Health Objective: HO 16-1 Fetal and Infant deaths

State Health Objective(s):

To reduce the infant mortality rate to no more than 4.5 per 1,000 live births, by September 30, 2010. *[Baseline: 6.8 per 1,000 live births]*
To reduce the neonatal death rate to no more than 2.9 per 1,000 live births, by September 30, 2010. *[Baseline: 4.5 per 1,000 live births]*

To increase the percentage of pregnant women who receive early and adequate prenatal care (as measured by the Kotelchuck Index) to at least 90% for all population groups, including Hispanic, by September 30, 2010.

(These objectives are taken from "Nebraska 2010 Health Goals and Objectives", published May 2002.)

State Health Problem:

Infant Deaths:

- A total of 178 infant deaths occurred among Nebraska residents in 2002, which translates into an infant mortality rate of 7.0 per 1,000 live births. This figure represents a slight increase from the infant mortality rate of 6.8, which tied the 1999 figure as the lowest infant mortality rate ever recorded in Nebraska's history. As in recent years, the two leading causes of infant deaths in Nebraska in 2002 were birth defects and Sudden Infant Death Syndrome (SIDS), which accounted for 42 and 18 infant deaths, respectively. Low birth weight babies accounted for 118 (66.3%) of Nebraska's infant deaths, with 90 of these children falling into the very low birth weight (below 1500 grams) category. Neonates (infants less than 28 days old) accounted for about two-thirds of Nebraska's 2002 infant deaths, with a count of 121, while post-neonates (infants between 28 days and one year of age) accounted for the remaining 57 deaths.

[Source: Nebraska Vital Statistics Report, 2002, published by the NHHSS]

- A total of 141 infant deaths occurred among Nebraska residents in 2003, which translates into an infant mortality rate of 5.4 per 1,000 live births. This figure represents a substantial decrease from the 2002 rate, and is the lowest infant mortality rate ever recorded in the state's history. As in recent years, the two leading causes of infant deaths in Nebraska in 2003 were birth defects and Sudden Infant Death Syndrome (SIDS), which resulted in 36 and 24 infant deaths respectively. Low birth weight babies accounted for 88 (62.4%) of Nebraska's infant deaths, with 68 of these children falling into the very low birth weight (<1500 grams) category. Neonates (infants less than 28 days old) accounted for about two-thirds of Nebraska's 2003 infant deaths, with a count of 96, while post-neonates (infants between 28 days and one year of age) accounted for the remaining 45.

[Source: Nebraska 2003 Vital Statistics Report, published August 2004 by NHHSS]

Prenatal Care:

The proportion of women receiving early and adequate prenatal care by racial and ethnic group:

- White 73.8 %
- African American 74.9 %

- Native American 65.0 %
- Asian American 52.9 %
- Hispanic 73.2 %

[Source: Nebraska 2010 Goals and Objectives, NHHSS, May 2002]

Target Population:

Nebraska defines Target Population as the number of births per year, based on the 2002 figure.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as the number of low birth weight births, based on the number in 2002.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: Under 1 year
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 7 - Link people to services:

Desired Impact Objective: To assure adequate and proper prenatal care for Hispanic women in one county, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will provide case management for 60 Hispanic women, with limited English speaking proficiency, linking them to needed services, by September 30, 2006.

National Health Objective: **HO 27-10 Exposure to environmental tobacco smoke**

State Health Objective(s):

To maintain compliance with the Nebraska Clean Indoor Air Act at no less 80% of public places inspected, by September 30, 2010.

[Baseline: estimated percentage compliance to Nebraska's Clean Indoor Air Act, in 2002 was 90%]

The Nebraska Clean Indoor Air Act prohibits "smoking in public places and at public meetings". Enforcement of the Clean Indoor Air Act is the responsibility of the Nebraska Health and Human Services System, Department of Regulation and Licensure. Local authorities conduct enforcement activities in their respective counties. These include Hall, Douglas, Lancaster, Sarpy, Scotts Bluff, Platte, Colfax, Boone, and Madison Counties.

- There is no systematic proactive enforcement of the Nebraska Clean Indoor Air Act.
- The Clean Indoor Air Act is a uniform act requiring all establishments to comply with the law.
- No person shall smoke in a public place except in designated smoking areas.
- If smoking areas are designated, the area shall be proportionate to the preference of users.
- No person shall smoke in an indoor place of work where smoke pollution causes discomfort.
- Designated smoking areas should be properly vented and utilize existing barriers.
- Proper signage indicating smoke-free, smoking in designated areas, or smoking in entirety must be posted on each entrance.
- Restaurants with less than 1200 square feet or a bar may declare an establishment smoking in its entirety

State Health Problem:

Effects of Environmental Tobacco Smoke (ETS)

In 1986, two landmark reports were published on the association between environmental tobacco smoke (also known as second-hand smoke or passive smoking) and adverse health effects in non-smokers. Prepared by the U.S. Surgeon General and the National Academy of Sciences, both reports concluded that: 1) ETS can cause lung cancer in healthy adult non-smokers; 2) children of parents who smoke have more respiratory symptoms and acute lower respiratory tract infections, as well as evidence of reduced lung function, than do children of non-smoking parents; and 3) separating smokers and non-smokers within the same airspace may reduce but does not eliminate a non-smoker's exposure to ETS. In 1992, the U.S. Environmental Protection Agency (EPA) confirmed these findings in its own study of the respiratory health effects of ETS, and also estimated that ETS was responsible for approximately 3,000 lung cancer deaths per year among non-smokers in the United States.

Additional research has documented many more ETS-related health effects. In adults, ETS exposure increases the risk of heart attack and nasal sinus cancer, and it can worsen pulmonary symptoms for those with asthma, chronic bronchitis, and allergic conditions. However, children appear to suffer disproportionately from the effects of ETS. Children exposed to ETS have an increased risk of ear infections, pneumonia, bronchitis, and tonsillitis. The EPA estimates that between 150,000 and

300,000 American children age 18 months and younger get bronchitis or pneumonia every year from breathing ETS. ETS is also a risk factor for childhood asthma, and it can increase the frequency and severity of asthma attacks in children.

Policy and regulation:
In the wake of the reports on ETS that were released by the Surgeon General and the National Academy of Sciences in 1986, many new laws, regulations, and ordinances were enacted that either restricted or banned public smoking. At the federal level, smoking is now limited to designated areas within federal office buildings, and some federal agencies have prohibited smoking altogether. By law, smoking is no longer allowed on airline flights of six hours or less within the United States, and all U.S. airlines have taken the additional step of banning smoking on all domestic flights. At the state level, most states have also passed legislation that restricts or bans public smoking. **In Nebraska, smoking is now restricted in government and private work sites, restaurants, bars, grocery stores, enclosed arenas, hospitals, and on public transportation.**

Although the regulatory efforts of the past 15 years have undoubtedly reduced or eliminated ETS exposures in many environments, ETS exposures that occur within unregulated environments, particularly private residences, constitute a substantial public health hazard, especially in light of the pronounced effect of ETS on children. The most recent national data on this subject were collected as part of the 1994 NHIS, and found that 27 percent of American children under the age of seven live in a household in which at least one resident smokes inside the home at least four days per week. The survey included cigar and pipe smoking, in addition to cigarettes. Data from the 1994 NHIS are not available for Nebraska alone, but similar data are available from the 1998 Nebraska BRFSS. **According to the BRFSS, 28 percent of Nebraska children under the age of six live in a household in which at least one person has smoked a cigarette, cigar, or a pipe within the home during the past 30 days.**

[Source: "Nebraska 2010 Health Goals and Objectives", published May 2002 by the Nebraska Health and Human Services System]

Facts about ETS in Nebraska:

- Approximately 10 percent of public places inspected were found to be out of compliance with the Nebraska Clean Indoor Air Act in 2002. [Source: NHHSS NCIAA report]
- A total of 873,197 people over the age of 16 worked outside their homes during 2000. [Source: Nebraska Department of Economic Development, from 2000 census data]
- The percentage of people protected by secondhand smoke policies at work and home is somewhat lower in Nebraska (60%), compared to model tobacco control states (68%). [Source: NCI and CDC. unpublished data, 2001] That would mean 684,400 Nebraskans are not protected by second hand smoke policies.
- When asked about their environment while on the job, 72% of Nebraska adults said they are indoors most of the time. The presence of secondhand smoke in the workplace would represent a serious health hazard. Respondents were asked about the smoking policy for indoor public or common areas in their place of work. Nearly three-fourths of Nebraskans (74%) said smoking was not allowed in some public areas. Less than one in ten respondents said their workplace had no official policy or allowed smoking in all public places.

[Source: BRFSS, State of Nebraska. 1997-98]

Exposure varies, but is probably zero for exceedingly few Nebraskans. Many people, of all ages, may

encounter ETS in multiple public and private locations. Moreover, their exposure is not eliminated even when public places are in perfect compliance to the NCIAA.

Target Population:

Nebraska defines the Target Population as the nonsmokers exposed to environmental tobacco smoke (ETS) in public places:food and non-food establishments, worksites, and other public buildings.

The extent of exposure to ETS varies, but most Nebraskans are probably exposed occasionally. Many people, of all ages, may encounter ETS in multiple public and private locations. Moreover, their exposure is not eliminated even when public places are in perfect compliance to the Nebraska Clean Indoor Air Act . (See State Program Strategy section for a discussion of efforts to move towards a smoke-free environment.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Nebraska defines the Disparate Population as about 20 percent of the Target Population, who may be at highest risk of developing certain cancers because of multiple exposures to environmental tobacco smoke.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, White
Age: All ages
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 6 - Enforce laws and regulations:

Desired Impact Objective: To determine rates of compliance with the Nebraska Clean Indoor Air Act in public places by conducting inspections and reinspection, by September 30, 2009.

> **Annual Activity Objective:** Subawardee will conduct 50 random inspections of licensed food and non-food establishments, reinspect 25 establishments and contact with local health departments to perform 100 followup inspections, by September 30, 2006.

PROGRAM PROFILE

1. Program Title: SPECIAL POPULATIONS PROGRAM

2. Total Block Grant Funds to Program:

Current Year:

a. HO 7-5	$25,000
b. HO 7-10	$238,260
c. HO 7-11	$115,639
d. HO 16-1	$20,000
e. HO 27-10	$12,366
Total:	$411,265

Prior Year:

a. HO 7-5	$0
b. HO 7-10	$0
c. HO 7-11	$0
d. HO 16-1	$0
e. HO 27-10	$0
Total:	$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 7-5	$25,000
b. HO 7-10	$0
c. HO 7-11	$20,000
d. HO 16-1	$20,000
e. HO 27-10	$0
Total:	$65,000

4. Total FTE's for Program:

Number:

a. HO 7-5	0.25
b. HO 7-10	1.00
c. HO 7-11	1.05
d. HO 16-1	0.00
e. HO 27-10	0.00
Total:	2.30

Description (Optional): The PHHS Block Grant direct costs of NHHSS staff, as well as support to a local health department project.

HEALTH OBJECTIVE PROFILE for HO 7-5 Worksite health promotion programs

5a. National Health Objective: 7-5 Worksite health promotion programs

Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.
34 percent of worksites with 50 or more employees offered a comprehensive health promotion program in 1999. 33 percent of worksites with 50 to 99 employees in 1999. 33 percent of worksites with 100 to 249 employees in 1999. 38 percent of worksites with 250 to 749 employees in 1999. 50 percent of worksites with 750 or more employees in 1999.

6a. State Health Objective(s):

To improve health status of workers and protect the worksite environment in Nebraska, by September 30, 2010.

7a. Target and Disparate Population Numbers:

Target Number: 50,000
Disparate Number: 25,000

8a. HO Dollars/FTE's:

(1). Total Current Year: $25,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $10,000
(4). Number of FTE's for HO: 0.25
(5). Amount of $'s to Local Entities for HO: $25,000

Description (Optional): One local health department facilitates health promotion programs at worksites.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 7-5 10-49% - Partial source of funding

10a. Block Grant Role:

HO 7-5 Supplemental Funding

Description (Optional): The PHHS Block Grant supports worksite health promotion in one county.

11a. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 7-10 Community health promotion programs

5b. National Health Objective: 7-10 Community health promotion programs

Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas. An operational definition has not been specified.

6b. State Health Objective(s):

To improve the health status of Nebraska's communities, by September 30, 2010.

7b. Target and Disparate Population Numbers:

Target Number: 63,000
Disparate Number: 31,500

8b. HO Dollars/FTE's:

(1). Total Current Year: $238,260
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $100,000
(4). Number of FTE's for HO: 1.00
(5). Amount of $'s to Local Entities for HO: $0

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 7-10 100% - Total source of funding

10b. Block Grant Role:

HO 7-10 No other existing federal or state funds

Description (Optional): The PHHS Block Grant supports health promotion activities carried out by local health departments and NHHSS staff.

11b. 10 Essential Services

Essential Service 4 - Mobilize partnerships
Essential Service 5 - Develop policies and plans
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 7-11 Culturally appropriate community health promotion programs

5c. National Health Objective: 7-11 Culturally appropriate community health promotion programs

Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.
An operational definition has not been specified.

6c. State Health Objective(s):

To improve the health status of Nebraskans who are members of racial and ethnic minorities, eliminating the disparity in health status compared to the white population, by September 30, 2010.

7c. Target and Disparate Population Numbers:

Target Number: 190,000
Disparate Number: 190,000

8c. HO Dollars/FTE's:

(1). Total Current Year: $115,639
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $40,639
(4). Number of FTE's for HO: 1.05
(5). Amount of $'s to Local Entities for HO: $20,000

Description (Optional): The PHHS Block grant supports a project operated by a district health department, aimed at improving the health of the Hispanic population of a two county area..

9c. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 7-11 10-49% - Partial source of funding

10c. Block Grant Role:

HO 7-11 Supplemental Funding

Description (Optional): The PHHS Block Grant supports a portion of the cost of operating the Office of Minority Health and Human Services within NHHSS, as well as a project operated by a district health department.

11c. 10 Essential Services

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate
Essential Service 5 - Develop policies and plans
Essential Service 9 - Evaluate health programs

HEALTH OBJECTIVE PROFILE for HO 16-1 Fetal and Infant deaths

5d. National Health Objective: 16-1 Fetal and Infant deaths

Reduce fetal and infant deaths.
6.8 fetal deaths at 20 or more weeks of gestation per 1,000 live births in 1997.

6d. State Health Objective(s):

To reduce the infant mortality rate to no more than 4.5 per 1,000 live births, by September 30, 2010. *[Baseline: 6.8 per 1,000 live births]*
To reduce the neonatal death rate to no more than 2.9 per 1,000 live births, by September 30, 2010. *[Baseline: 4.5 per 1,000 live births]*

To increase the percentage of pregnant women who receive early and adequate prenatal care (as measured by the Kotelchuck Index) to at least 90% for all population groups, including Hispanic, by September 30, 2010.

(These objectives are taken from "Nebraska 2010 Health Goals and Objectives", published May 2002.)

7d. Target and Disparate Population Numbers:

Target Number: 253,000
Disparate Number: 1,820

8d. HO Dollars/FTE's:

(1). Total Current Year: $20,000
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $20,000
(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $20,000

Description (Optional): PHHSBG funds support a project conducted by a district health department aimed at Spanish-speaking pregnant women.

9d. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 16-1 10-49% - Partial source of funding

10d. Block Grant Role:

HO 16-1 Supplemental Funding

Description (Optional): PHHSBG funds support a project conducted by a District Health Department, outside the NHHSS. That project serves pregnant Hispanic women.

11d. 10 Essential Services

Essential Service 7 - Link people to services

HEALTH OBJECTIVE PROFILE for HO 27-10 Exposure to environmental tobacco smoke

5e. National Health Objective: 27-10 Exposure to environmental tobacco smoke

Reduce the proportion of nonsmokers exposed to environmental tobacco smoke
65 percent of nonsmokers aged 4 years and older who had a serum cotinine level above 0.10 ng/mL in 1988-94.

6e. State Health Objective(s):

To maintain compliance with the Nebraska Clean Indoor Air Act at no less 80% of public places inspected, by September 30, 2010.

[Baseline: estimated percentage compliance to Nebraska's Clean Indoor Air Act, in 2002 was 90%]

The Nebraska Clean Indoor Air Act prohibits "smoking in public places and at public meetings". Enforcement of the Clean Indoor Air Act is the responsibility of the Nebraska Health and Human Services System, Department of Regulation and Licensure. Local authorities conduct enforcement activities in their respective counties. These include Hall, Douglas, Lancaster, Sarpy, Scotts Bluff, Platte, Colfax, Boone, and Madison Counties.

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- No person shall smoke in an indoor place of work where smoke pollution causes discomfort.
- Designated smoking areas should be properly vented and utilize existing barriers.
- Proper signage indicating smoke-free, smoking in designated areas, or smoking in entirety must be posted on each entrance.
- Restaurants with less than 1200 square feet or a bar may declare an establishment smoking in its entirety

7e. Target and Disparate Population Numbers:

Target Number: 500,000
Disparate Number: 100,000

8e. HO Dollars/FTE's:

(1). Total Current Year: $12,366
(2). Total Prior Year: $0
(3). Amount to Disparate Population: $0

(4). Number of FTE's for HO: 0.00
(5). Amount of $'s to Local Entities for HO: $0

9e. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 27-10 10-49% - Partial source of funding

10e. Block Grant Role:

HO 27-10 Supplemental Funding

Description (Optional): The PHHSBG supports a fraction of the compliance inspections for the Clean Indoor Air Act, a portion of the Tobacco Free Nebraska Program and one project operated by an urban local health department.

11e. 10 Essential Services

Essential Service 6 - Enforce laws and regulations